U.S. Department of Health and Human Services

CMS Financial Report

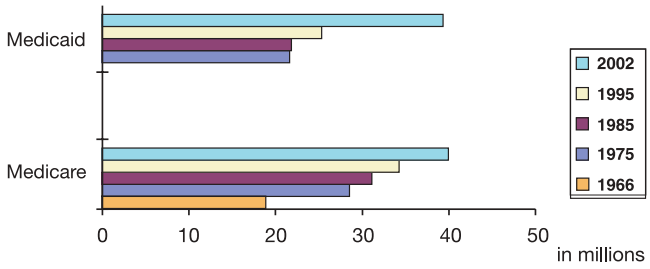
Fiscal Year 2002

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

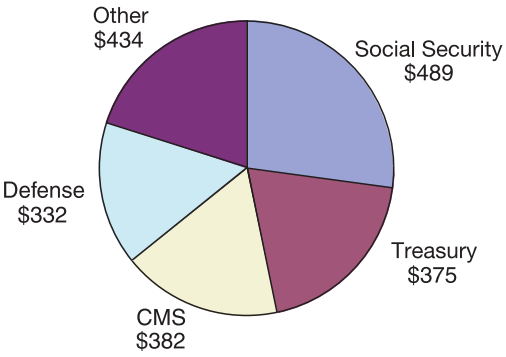
The Centers for Medicare & Medicaid Services At a Glance

The **CMS** is the largest purchaser of health care in the world. The Medicare, Medicaid, and State Children's Health Insurance programs that we administer provide health care for one in four Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to over 40 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to 39 million beneficiaries.

2002 Program Enrollment



2002 Federal Outlays



Source: U.S. Treasury

$ in billions

The **CMS** outlayed $381.7 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2002, 19 percent of total Federal outlays. The only agency that outlayed more is the Social Security Administration.

The **CMS** has approximately 4,500 Federal employees, but does most of its work through third parties. The CMS and its contractors process 998 million Medicare claims annually, monitor quality of care, provide States with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. We also assure the safety and quality of medical facilities, provide health insurance protection to workers changing jobs, and maintain the largest collection of health care data in the United States.

Administrator
Washington, DC 20201

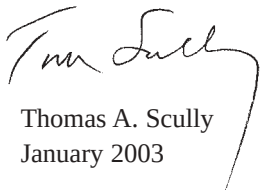
A Message from the Administrator

The Centers for Medicare & Medicaid Services (CMS) Financial Report for Fiscal Year (FY) 2002 demonstrates how effectively CMS managed outlays of over $400 billion and provided quality health care services to over 80 million beneficiaries through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). We have been steadfast in meeting our mission: assuring health care security for beneficiaries. We have refined our vision to emphasize quality and efficiency in an evolving health care system. We have identified five core values—public service, integrity, accountability, excellence, and respect—that will guide us in accomplishing our mission and goals.

I am pleased with the progress that we have made after a full year with our new name and new structure focused on our three major lines of business—traditional fee-for-service Medicare, Medicare beneficiary-centered choice, and state-administered programs, such as Medicaid and SCHIP. We continue to raise the service level of our programs through a series of routinely scheduled Open Door Forums and Listening Sessions held around the country that have shown great success. We service each state with two account representatives to help troubleshoot, resolve disputes, ease communication, and resolve bureaucratic bottlenecks. We have created the CMS Quarterly Provider Update to provide the health care community with regular and predictable information on new developments in CMS programs. We have also launched several provider outreach efforts to make it easier and less burdensome for physicians, other health care professionals, and providers to deliver high quality services. The CMS continues to work toward a prescription drug benefit for our Medicare beneficiaries.

We are continuing our national advertising campaign as part of our education initiative to assure Medicare beneficiaries understand information resources available to them so they can become better informed participants in their health care choices. We also continue to offer call center services at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week and a Medicare consumer information web site, *www.medicare.gov*, to assist our beneficiaries in understanding the health care options available to them at their convenience. We have many strategic goals designed to support the President's Management Agenda. For example, our strategic goal of promoting the fiscal integrity of CMS programs and being an accountable steward of public funds will improve financial performance. We have also delayered the Agency and taken other initiatives to strategically manage our human capital.

I look forward with confidence that CMS and its partners will continue to provide the best health care possible for our Nation's beneficiaries.



Thomas A. Scully
January 2003

Deputy Administrator and Chief Operating Officer

Baltimore, MD 21244-1850

A Message from the Deputy Administrator and Chief Operating Officer

As CMS's Deputy Administrator and Chief Operating Officer, I am pleased to join the Administrator and the CFO in presenting CMS's Financial Report for FY 2002. The report discusses CMS's FY 2002 performance and outlines programmatic, financial and management issues in order to assess accountability in meeting our mission of assuring health care security for beneficiaries.

We have carried out the commitments of President George W. Bush and the Department of Health and Human Services (HHS) Secretary Tommy Thompson to improve the delivery of public services. For example, we continue to deploy resources in a more customer-oriented way. We have identified six strategic goals, eight program objectives, and twelve operational objectives that support the President's Management Agenda. We have continued to review the Agency's functions and where appropriate have reorganized responsibilities and operations to be more responsive to our customers and partners. We have created a new financial management infrastructure to support the Healthcare Integrated General Ledger Accounting System (HIGLAS) project. The HIGLAS project is a critical CMS initiative that will significantly improve our oversight of contractor accounting systems. The new system will also strengthen Medicare's management of its accounts receivable and allow more timely and effective collection activities on outstanding debts. The project includes pilots at two Medicare contractors before national implementation.

Since our reorganization in June 2001, we have focused on six primary objectives: 1) restructuring, 2) integrating budget and performance, 3) enhancing strategic management of human capital, 4) increasing competitive sourcing, 5) improving financial performance, and 6) expanding electronic government. Our restructuring has increased manager span of control. In addition, we have redeployed resources to move the Agency toward being citizen-centered, results oriented, market aware, and effective. Our new project management team and internal audit function have improved the performance of CMS components and our contractors. They have strengthened the internal control environment and enhanced contractors' ability to be more effective at safeguarding taxpayer dollars, more accurate and prompt in making payments to providers, and more efficient at processing beneficiaries' claims for health care services.

Timely and consistent communication is a hallmark of an effective organization. Our focus is to be open and responsive; to that end, CMS has created mechanisms that will give our employees a greater opportunity to receive and act on feedback from our constituencies. I look forward to hearing the concerns and individual suggestions for improvement from physicians and other health care providers, from the people who deal with CMS in communities and facilities on a daily basis, and from seniors who rely upon Medicare and Medicaid for their health care needs.

Ruben J. King-Shaw, Jr.
January 2003

A Message from the Chief Financial Officer

As the Chief Financial Officer (CFO), I am pleased to present the CMS Financial Report for FY 2002. The CMS continues to proactively collaborate with the Department of Health and Human Services (DHHS), the Office of Inspector General (OIG), State agencies, Medicare contractors, and our beneficiaries to manage the financial complexity of our programs. This report reflects the steady progress that our Agency has made in achieving our financial management goals. As a result of these efforts, I am pleased to report that CMS's financial statements received an unqualified audit opinion for the fourth consecutive year. This report presents the financial health of Medicare's Hospital Insurance and Supplementary Medical trust funds separately, based on standards in effect at the time of the audit. Going forward, the Administration plans to develop a more comprehensive measure of Medicare's and Medicaid's financial position that will analyze the Medicare program as a whole.

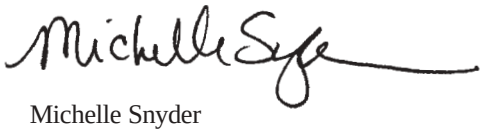
A key element of our strategic vision is to implement a state-of-the-art financial management system that fully integrates CMS's accounting system with those of our Medicare contractors. This project is called the Healthcare Integrated General Ledger Accounting System (HIGLAS). The HIGLAS will also strengthen Medicare's management of its accounts receivable and allow more effective collection activities on outstanding debt. This project is well underway—using International Business Machines, Oracle Corporation, and Electronic Data Systems as teaming partners.

We updated and enhanced the Chief Financial Officer Comprehensive Plan for Financial Management for FY 2002 to coordinate our financial management goals. With respect to these goals and other financial initiatives, FY 2002 was a successful year for the financial management of the Agency. During the year, CMS:

- Reduced fraud, waste, and abuse in the Medicare program by reducing the Medicare payment error rate since 1996. For FY 2002, the OIG reported that the Medicare fee-for-service error rate is 6.3%.
- Initiated the Medicaid payment accuracy measurement project with nine States.
- Continued to make substantive progress in implementing the Debt Collection Improvement Act. We referred a total of $5.5 billion of delinquent debt for collection to the Department of Treasury. We have referred about 90% of all eligible delinquent debt to Treasury.
- Revised and issued a Medicare contractor financial management manual on the Internet.
- Hosted two national CFO training conferences to ensure that our Medicare contractors understand new policies and procedures so that their reported information is accurate, reliable, and uniform.
- Created four workgroups to address key Medicare contractor financial oversight areas including Corrective Action Plans, CMS 1522 Cash Reconciliation, Trend Analysis, and Certification Package for Internal Controls.

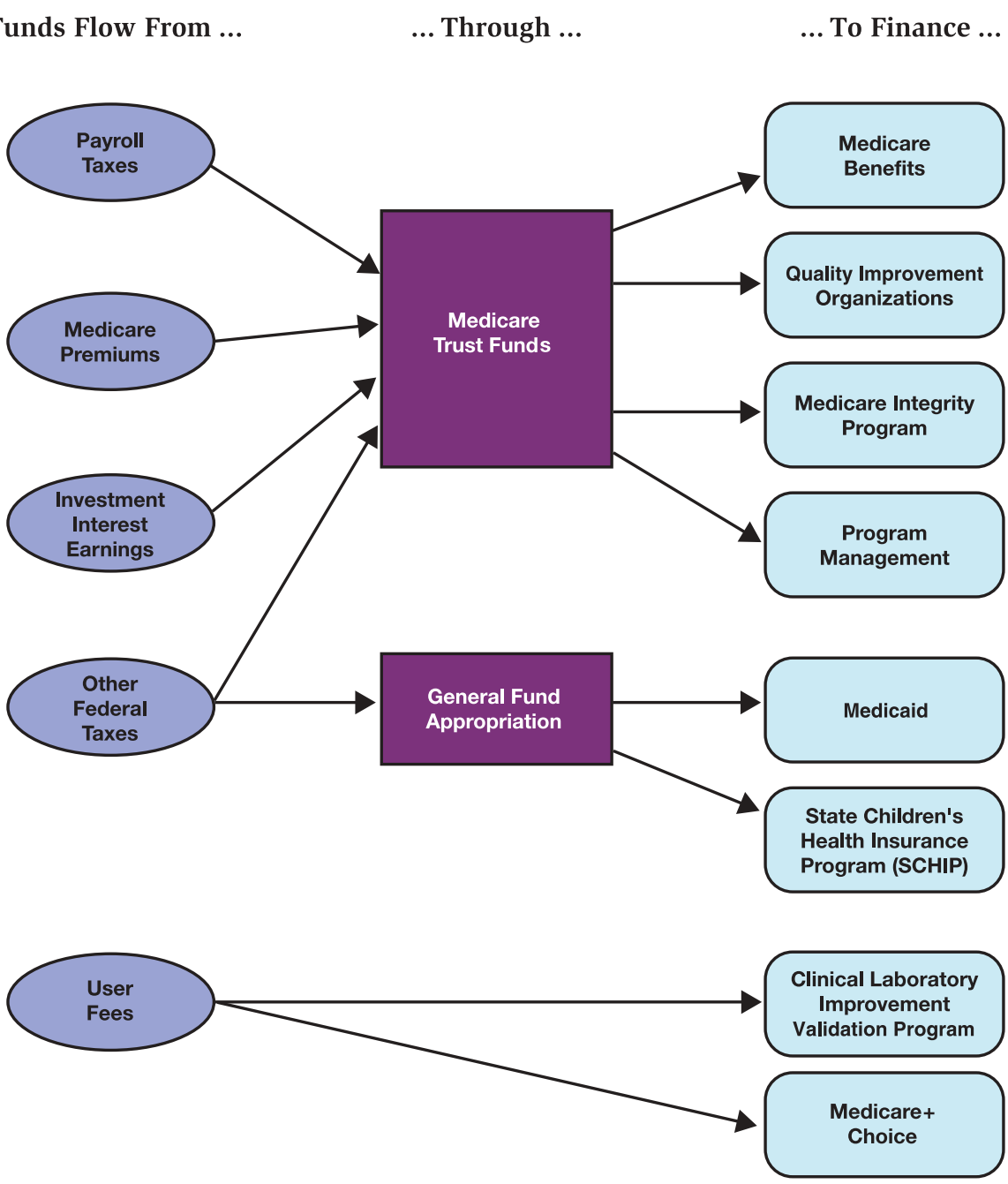
- Improved/strengthened our oversight of Medicare contractors' financial management processes and financial data.
- Increased Medicaid financial management audits.

While we have made many improvements in FY 2002, we will continue to further refine and improve our financial management goals. As the CFO, I remain committed to the stewardship responsibilities needed to maintain the highest level of accountability for the management of the Agency's financial resources.



Michelle Snyder
January 2003

Financing of CMS Programs and Operations



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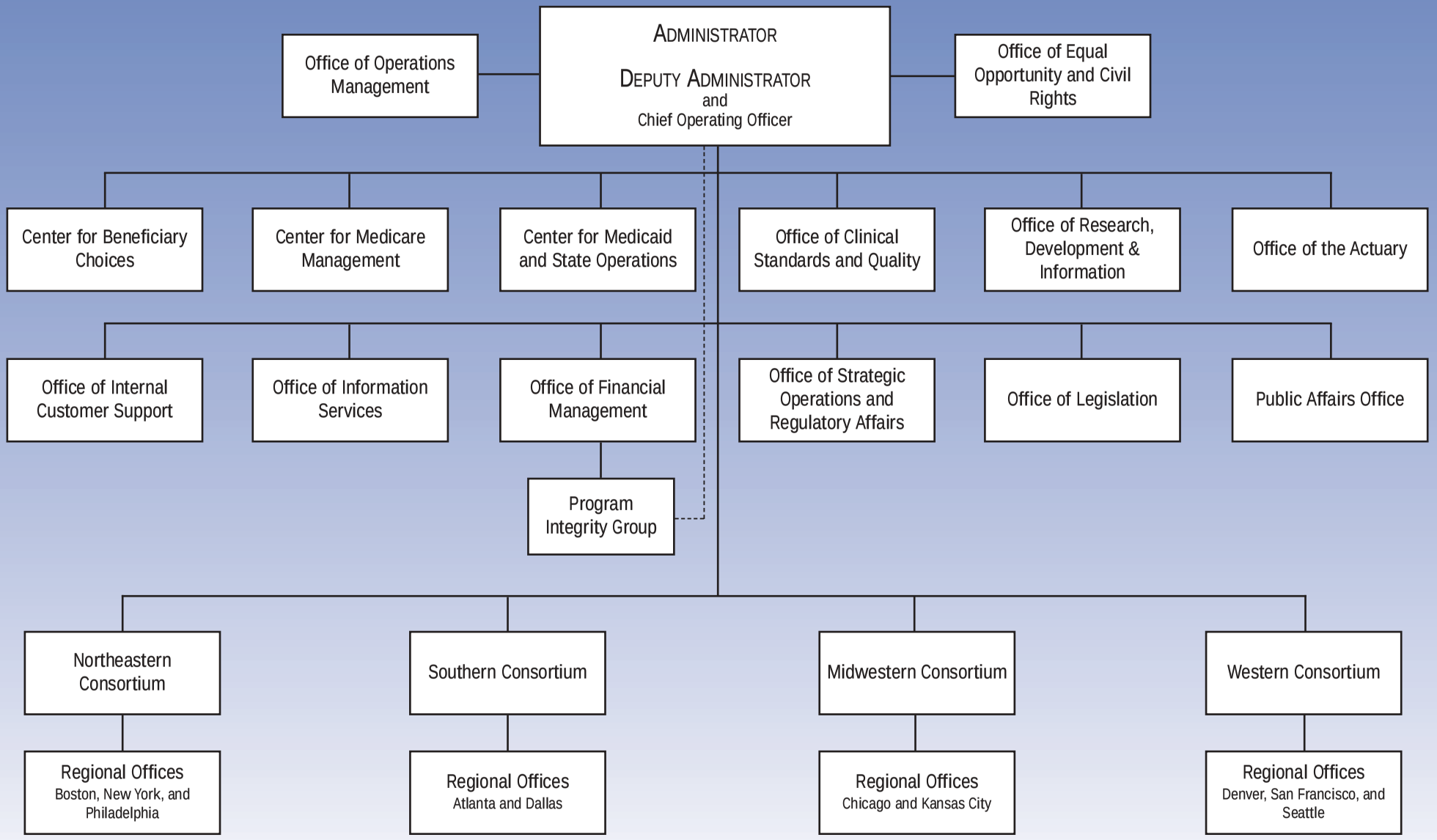
Approved Structure
As of January 2003

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES



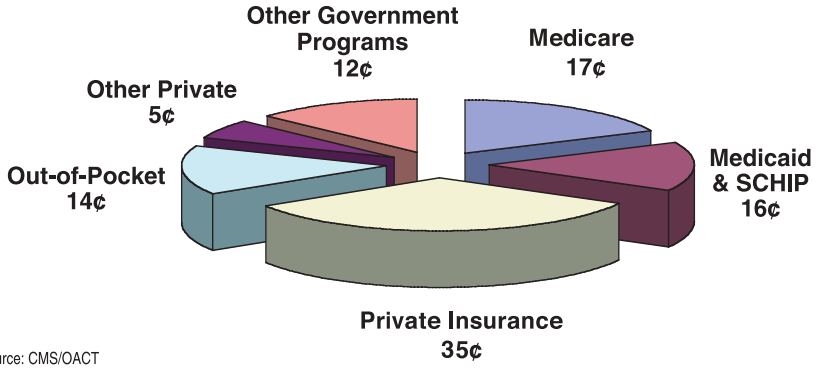
Management's Discussion and Analysis

OVERVIEW

The Centers for Medicare & Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS), administers Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and the Clinical Laboratory Improvement Validation program. Along with the Departments of Labor and Treasury, CMS also implements the insurance reform provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The CMS is the largest purchaser of health care in the world. Medicare, Medicaid, and SCHIP outlays, including State funding, represent 33 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three different perspectives, 59 cents of

The Nation's Health Care Dollar 2001



Source: CMS/OACT
Note: 2001 is the most current data.
Figures do not add to $1.00 due to rounding.

every dollar spent on nursing homes, 47 cents of every dollar received by U.S. hospitals, and 28 cents of every dollar spent on physician services.

The CMS **outlays** totaled $381.7 billion (net of offsetting receipts) in FY 2002. Our **expenses** totaled $410.9 billion, of which $2.6 billion (less than 1 percent) were administrative expenses.

Expenses are computed using the accrual basis of accounting that recognizes costs when incurred and revenues when earned regardless of the timing of cash received or disbursed. Expenses include the effect of accounts receivable and accounts payable on determining the net cost of operations. **Outlays** refer to cash disbursement made to liquidate an expense regardless of the fiscal year the expense was incurred.

We establish policies for program eligibility and benefit coverage, process 998 million Medicare claims annually, provide States with funds for Medicaid and SCHIP, ensure quality of health care for beneficiaries, and safeguard funds from fraud, waste, and abuse. Of our approximately 4,500 Federal employees, about 1,600 work in 10 regional offices (ROs) around the country to provide direct services to Medicare contractors, State agencies, health care providers, beneficiaries, and the general public. Approximately 2,900 of our employees work in Baltimore, MD and Washington, DC, where they provide funds to Medicare contractors; write policies and regulations; set payment rates; safeguard the fiscal integrity of the Medicare and Medicaid programs to ensure that benefit payments for medically necessary services are paid correctly the first time; recover improper payments; assist law enforcement agencies in the prosecution of fraudulent activities; monitor contractor performance; develop and implement customer service improvements; provide education and outreach activities to beneficiaries, survey hospitals, nursing homes, labs, home health agencies and other health care facilities; work with State insurance companies; and assist States and Territories with Medicaid and SCHIP. We also maintain the Nation's largest collection of health care data and provide technical assistance to the Congress, the Executive Branch, universities, and other private sector researchers.

Many important activities are also handled by third parties: (1) State employees administer Medicaid and SCHIP; (2) 22,100 employees at 47 Medicare contractors process Medicare claims, provide technical assistance to providers and service beneficiaries' needs, including premium billing, and respond to inquiries; (3) 6,100 State employees inspect hospitals, nursing homes, and other facilities to ensure that health and safety standards are met; and (4) employees at 53 Quality Improvement Organizations (QIOs) conduct a wide variety of quality improvement programs to ensure quality of care provided to Medicare beneficiaries.

PROGRAMS

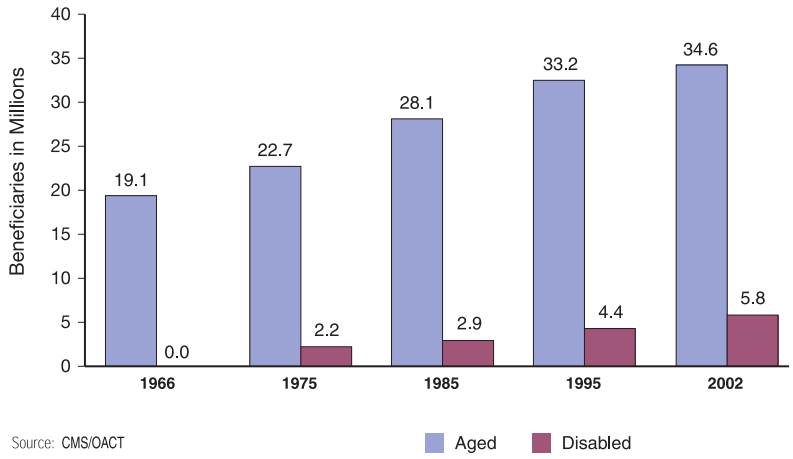
Medicare

Introduction

Established in 1965 as title XVIII of the Social Security Act, Medicare was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people aged 65 and over. In 1972, the program was changed to cover the disabled, people with end-stage renal disease (ESRD) requiring dialysis or kidney transplant, and people age 65 or older who elect Medicare coverage.

Medicare processes 998 million fee-for-service claims a year, is the nation's largest purchaser of managed care, and accounts for more than 11 percent of the Federal Budget. Medicare is a combination of three programs: Hospital Insurance, Supplementary Medical Insurance, and Medicare+Choice. Since 1966, Medicare enrollment has increased from 19 million to over 40 million beneficiaries.

Medicare Enrollment



Source: CMS/OACT

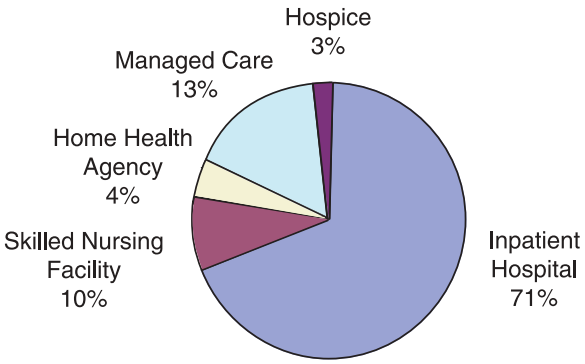
Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. HI pays for hospital, skilled nursing facility, home health, and hospice care.

The HI program is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities.

Inpatient hospital spending accounted for 71 percent of HI benefits outlays. Managed care spending comprised 13 percent of total HI outlays. During FY 2002, HI benefit outlays grew by 4.5 percent. The HI benefit outlays per enrollee increased by 2.9 percent to $3,633.

HI Medicare Benefit Payments

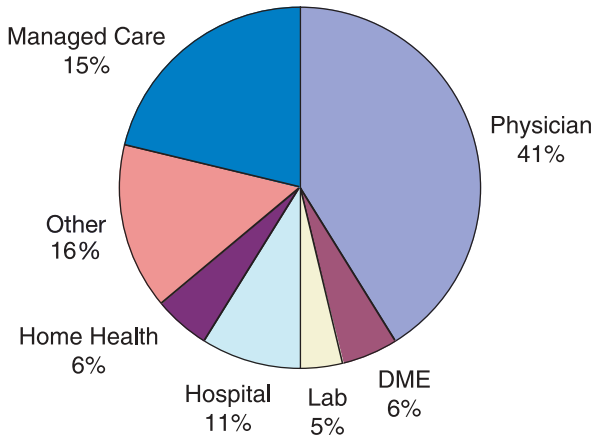


Source: CMS/OACT
Note: Figures do not add to 100% due to rounding.

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is available to nearly all people aged 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, and other services not covered by HI. The SMI coverage is optional and beneficiaries are subject to monthly premium payments. About 95 percent of HI enrollees elect to enroll in SMI.

SMI Medicare Benefit Payments



Source: CMS/OACT

The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the SMI trust fund, and invested in U.S. Treasury securities.

During FY 2002, SMI benefit outlays grew by 9.8 percent. Physician services, the largest component of SMI, accounted for 41 percent of SMI benefit outlays. The SMI benefit outlays per enrollee increased 9.3 percent to $2,820.

Medicare+Choice

The Balanced Budget Act of 1997 (BBA) created the Medicare+Choice (M+C) program, which was designed to provide more health care coverage choices for Medicare beneficiaries. Those who are entitled because of age (65 or older) or disability may choose to join an M+C plan if they are entitled to Part A and enrolled in Part B, if there is a plan available in their area. Those who are entitled to Medicare because of ESRD may join an M+C plan only under special circumstances.

Medicare beneficiaries have long had the option to choose to enroll in prepaid health care plans that participate in Medicare instead of receiving services under traditional fee-for-service (FFS) arrangements. Managed care organizations have their own providers or a network of contracting health care providers who agree to provide health care services for health maintenance organizations (HMO) or prepaid health organizations' members. Managed care organizations currently serve Medicare beneficiaries through coordinated care plans, which include HMOs, point-of-service (POS) plans offered by HMOs, preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs). Under M+C, beneficiaries may also choose to join a private FFS plan that is available in twenty-five States. Managed care demonstration projects, as well as cost and Health Care Prepayment Plans (HCPPs) options, also exist.

All M+C plans are paid a per capita premium, assume full financial risk for all care provided to Medicare beneficiaries, and must provide all Medicare covered services. Many M+C plans offer additional services such as prescription drugs, vision and dental benefits to beneficiaries. Cost contractors are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services, but do not always provide the additional services that some risk M+C plans offer. HCPPs are paid in a manner similar to cost contractors, but cover only non-institutional Part B Medicare services. Section 1876 cost-based contractors and HCPPs, with certain limited exceptions, phase out under the BBA provisions.

Managed care expenses are estimated to be $33.5 billion of the total $252.6 billion in Medicare benefit payment expenses in FY 2002.

Medicaid

Introduction

Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the States. Enacted in 1965 as title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients of cash assistance. Over the years, Congress incrementally expanded Medicaid well beyond the traditional population of the low-income elderly and the blind and disabled. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including poor families, the disabled,

and persons with developmental disabilities requiring long-term care. The average enrollment for Medicaid was 39 million in FY 2002, about 13 percent of the U.S. population. Nearly 7 million people are dually eligible, that is, covered by both Medicare and Medicaid.

The CMS provides matching payments to States and Territories to cover the Medicaid program and related administrative costs. State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. In FY 2002, the Federal matching rate for Medicaid program costs among the States ranged from 50 to 76 percent, with a national average of 57 percent. Federal matching rates for various State and local administrative costs are set by statute, and in FY 2002 averaged 55 percent. Medicaid payments are funded by Federal general revenues provided to CMS through the annual Labor/HHS/Education appropriations act. There is no cap on Federal matching payments to States, except with respect to the disproportionate share program and payments to Territories.

States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines that include providing coverage to persons receiving Supplemental Security Income (disabled, blind, and elderly population), low income families, the medically needy, pregnant women, young children, low-income Medicare beneficiaries, and certain other groups; and covering at least 10 services mandated by law, including hospital and physician services, laboratory tests, family planning services, nursing facility services, and comprehensive health services for individuals under age 21. State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to individual State circumstances and priorities. Accordingly, there is a wide variation in the services offered by States.

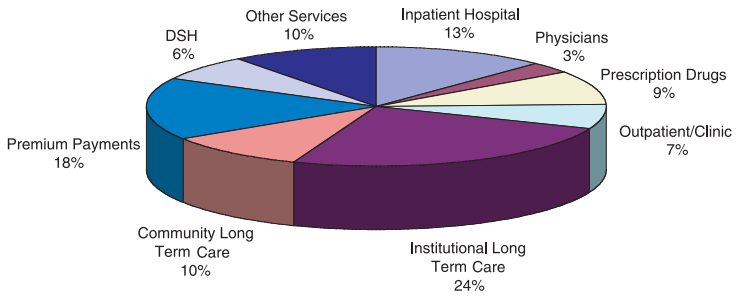
Medicaid is the largest single source of payment for health care services for persons with Acquired Immune Deficiency Syndrome (AIDS). Medicaid now serves over 50 percent of all AIDS patients and pays for the health care costs of most of the children and infants with AIDS. Medicaid spending for AIDS care and treatment in FY 2002 is estimated to be about $7.7 billion. In addition, the Medicaid programs of all 50 States and the District of Columbia provide coverage of all drugs approved by the Food and Drug Administration for treatment of AIDS.

Payments

Under Medicaid, State payments for both medical assistance payments (MAP) and administrative (ADM) costs are matched with Federal funds. In FY 2002, State and Federal ADM gross outlays were $14 billion, about 5.4 percent of the gross Medicaid outlays. State and Federal MAP gross outlays are estimated at $244.5 billion or 95 percent of total Medicaid gross outlays, an increase of 12.4 percent over FY 2001. Thus, State and Federal MAP and ADM outlays for FY 2002 totaled $258.5 billion. The CMS share of Medicaid expenses totaled $146.9 billion in FY 2002.

Medicaid Medical Assistance Payments
FY 2002

Total Payments = $246 billion



Source: CMS/OACT

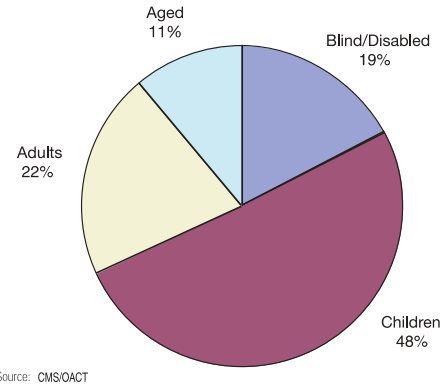
Enrollees

About 39 million persons were enrolled in Medicaid in 2002. Children comprise nearly 50 percent of Medicaid enrollees, but account for only 16 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 30 percent of Medicaid enrollees, but accounted for 66 percent of program spending. The elderly and disabled use more expensive services in all categories, particularly nursing home services.

Service Delivery Options

Many States are pursuing managed care as an alternative to the FFS system for their Medicaid programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications. Most States have taken advantage of waivers provided by CMS to introduce managed care plans tailored to their State and local needs, and 48 States now offer a form of managed care. The number of Medicaid beneficiaries enrolled in managed care has grown from slightly under 15 percent in 1993 to over 56 percent by 2001.

2002 Medicaid Enrollees



Source: CMS/OACT

The CMS and the States have worked in partnership to offer managed care to Medicaid beneficiaries. Moreover, as a result of the BBA, States may amend their State plan to require certain Medicaid beneficiaries in their State to enroll in a managed care program, such as a managed care organization or primary care case manager. Medicaid law provides for three kinds of waivers of existing Federal statutes to allow for the implementation of managed care:

1) State health reform waivers—Section 1115 of the Social Security Act provides broad discretion to waive certain provisions of Medicaid law for experimental, pilot, or demonstration projects. In August 2001, the President announced a section 1115 initiative, known as Health Insurance Flexibility and Accountability, to promote additional coverage of the uninsured.

2) Freedom of choice waivers—Section 1915(b) of the Social Security Act allows certain provisions of Medicaid law to be waived to allow States to develop innovative managed health care delivery or reimbursement systems.

3) State plan exceptions—Section 1932(a) of the Social Security Act allows States to mandate managed care enrollment for certain groups of Medicaid beneficiaries. States may elect to include the Program of All-Inclusive Care for the Elderly (PACE) as a State plan option. The PACE is a prepaid, capitated plan that provides comprehensive health care services to frail, older adults in the community, who are eligible for nursing homes according to State standards.

State Children's Health Insurance

The State Children's Health Insurance Program (SCHIP) was created through the BBA to address the fact that nearly 11 million American children—one in seven—were uninsured and therefore at increased risk for preventable health problems. Many of these children were in working families that earned too little to afford private insurance on their own, but too much to be eligible for Medicaid. Congress and the Administration agreed to set aside $24 billion over five years, beginning in FY 1998, to create SCHIP—the largest health care investment in children since the creation of Medicaid in 1965. These funds cover the cost of insurance, reasonable costs for administration, and outreach services to get children enrolled. To make sure that funds are used to cover as many children as possible, funds must be used to cover previously uninsured children, and not to replace existing public or private coverage. Important cost-sharing protections were also established so families would not be burdened with out-of-pocket expenses they could not afford.

The statute sets the broad outlines of the program's structure, and establishes a partnership between the Federal and State governments. States are given broad flexibility in tailoring programs to meet their own circumstances. States can create or expand their own separate insurance programs, expand Medicaid, or combine both approaches. States can choose among benchmark benefit packages, develop a benefit package that is actuarially equivalent to one of the benchmark plans, use the Medicaid benefit package, or a combination of these approaches.

States also have the opportunity to set eligibility criteria regarding age, income, and residency within broad Federal guidelines. The Federal role is to ensure that State programs meet statutory requirements that are designed to ensure meaningful coverage under the program.

We work closely with States, Congress, the Health Resources and Services Administration, and Federal agencies to meet the challenge of implementing this program and defining its parameters, while at the same time approving State plan amendments as quickly as possible. CMS provides extensive guidance and interim instructions so States can further develop their plans and use Federal funds to insure as many children as possible. Since September 30, 1999, all 50 States, the District of Columbia, and the Territories had approved child health plans. Of these, 21 are Medicaid expansions, 20 are separate State Child Health plans, and 15 are combination plans. In addition, 144 amendments and 11 section 1115 waivers have been approved that provide SCHIP funds to States to cover pregnant women and parents of children enrolled in Medicaid or SCHIP.

Other Activities

In addition to making health care payments on behalf of our beneficiaries, CMS makes other important contributions to the delivery of health care in the U.S.

Survey and Certification Program

We are responsible for assuring the safety and quality of medical facilities, laboratories, providers, and suppliers by setting standards, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. The survey and certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. We administer agreements with State survey agencies to conduct onsite facility inspections. Funding is provided through the Program Management and the Medicaid appropriations. Only certified providers, suppliers, and laboratories are eligible for Medicare or Medicaid payments.

Since 1985, there has been growth in the number of Medicare-certified facilities, with the largest increases in skilled nursing facilities, home health agencies, hospices, and end-stage renal dialysis facilities. The number of these types of facilities increased from about 20,000 in FY 1985 to about 45,000 in FY 2002.

Clinical Laboratory Improvement Program

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing specimens from the human body. We regulate all laboratory testing (whether provided to beneficiaries of CMS programs or to others) including those in physicians' offices. In partnership with the States, we certify and

inspect more than 14,000 laboratories each year. The CLIA program is a 100 percent user-fee financed program. The CLIA program is jointly operated by three HHS components: (1) CMS provides financial management of the program, contracts with surveyors to inspect labs, and offers general administrative support, (2) The Centers for Disease Control and Prevention (CDC) provides research support, and (3) The Food and Drug Administration (FDA) oversees test categorization.

Quality of Care

Through QIOs, ESRD Networks, State agencies, and others, CMS collaborates with health care providers and suppliers to promote the improved health status of Medicare and Medicaid beneficiaries in both FFS and managed care settings. These collaborative projects often employ a sequential process that includes setting priorities, collecting and analyzing data, identifying opportunities to improve care, establishing performance expectations, and selecting and managing one or more improvement strategies. One of the tools for improving patient care is the development and dissemination of quality indicators and the publication of performance information.

In addition, as we revise our conditions of participation or conditions of coverage for providers and suppliers, we are focusing on outcome-patient requirements that focus on the patient. We continue to believe that providers and suppliers must ensure that there is an effective quality assessment and performance improvement program to evaluate the provisions of patient care.

Coverage Policy

In today's health care market, every insurer and health care purchaser must deal with coverage policy. We established a process that provides current information on coverage issues on the CMS coverage Web site and also facilitates input from all stakeholders, including beneficiaries, through the Medicare Coverage Advisory Committee (MCAC). The MCAC holds open meetings and includes consumer and industry members. We also rely on state-of-the-art technology assessment and support from other Federal agencies, as well as considerable staff expertise.

Medicare is a leader in evidence-based decision making for coverage policy. Our own extensive payment data contain additional useful information that is used by the Agency for Healthcare Research and Quality (AHRQ) and others for assessing the effectiveness of a variety of medical treatments.

Insurance Oversight and Data Standards

We have primary responsibility for setting standards for the Medigap insurance offered to Medicare beneficiaries to help pay the coinsurance and deductibles that Medicare does not cover. We work with State insurance commissioners' offices to ensure that suspected violations of the laws governing the marketing and sales of Medigap are addressed.

We are also responsible for implementing the data standards provision of HIPAA, which is aimed at reducing administrative costs and burdens in the health care industry. It requires HHS to adopt national uniform standards for the electronic transmission of certain health information. We are working with both public and private organizations to develop the best standards possible with strong safeguards to ensure privacy of records. Although HIPAA does not mandate the collection or electronic transmission of any health information, it does require that adopted standards be used for any electronic transmission of specified transactions.

As a result of the insurance reform provisions of HIPAA, CMS has assumed a new role in relationship to State regulation of health insurance and health coverage. We work with the State Insurance Commissioners offices, the U.S. Department of Labor, and the Internal Revenue Service to implement these provisions. The common goal is to improve access to the group and individual health insurance markets for certain eligible individuals who move from job to job, or who lose their group health insurance coverage and must purchase coverage in the individual insurance market. These new consumer protections affect an estimated 160 million individuals.

PERFORMANCE GOALS

The CMS mission is to assure health care security for beneficiaries. The CMS Strategic Plan is developed in conjunction with the Strategic Plan of HHS and outlines our goals for achieving this mission. The CMS strategic planning process and the enactment of the Government Performance and Results Act (GPRA) have emphasized the themes of accountability, stewardship, and a renewed focus on the customer. The CMS vision reflects our commitment to work in partnership with others to serve the beneficiaries of CMS programs: "In serving beneficiaries, we will open our programs to full partnership with the entire health community to improve quality and efficiency in an evolving health care system." As we strive to improve both our programs and operations, we have articulated a set of core values (public service, integrity, accountability, excellence, and respect) that underlie our work. The values help clarify for ourselves and others how CMS staff need to operate to achieve our mission.

We assess progress toward achieving our strategic goals and objectives through CMS's Annual Performance Plan (APP) and Report. Our approach to performance measurement under GPRA has been to develop an annual performance plan with goals that are representative of our vast responsibilities. Consistent with GPRA principles, CMS identified a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to our role as a steward of billions of taxpayer dollars. The APP describes CMS performance goals and their linkage to longer-term strategic goals, our reinforcement of the President's Management Agenda (PMA), and the CMS budget. The PMA is reflected throughout our goals. For example, improvement

in strategic management of human capital will come from our goal to improve our workforce planning and improved financial performance will come from such goals as reducing the percentage of improper payments made under the Medicare fee-for-service program and increasing referral of eligible delinquent debt for cross servicing. The plan includes the steps to accomplish each performance goal, and establishes a method and data source for measuring and reporting. The FY 2002 performance plan includes 35 goals for CMS programs that highlight major program areas and budget categories. It reflects key Administration and CMS priorities for the next several years. Our performance goals reflect a sensitivity to customer needs and an awareness that meeting those needs will require flexibility and imagination, as well as sound business sense.

We are confident that performance measurement under GPRA will substantially improve our programmatic and administrative performance. Performance results provide constructive information about the success of CMS programs, activities, and initiatives. This information is useful in making policy and management choices in both the short and long term. In the following section, we highlight our FY 2002 performance goals and outcomes. Our progress will be submitted with the Annual Performance Report along with the President's budget request for FY 2004.

Strategic Goal
Protect and Improve Beneficiary Health and Satisfaction

Improve heart attack survival rates.

This nationwide, multi-year effort focuses on implementing known successful interventions for properly treating heart attacks and preventing subsequent heart attacks. Our target is to increase the 1-year survival rate following hospitalization for a heart attack by decreasing the mortality rate to 27.4 percent. The final data from 2000 (heart attacks occurred between August 1999–July 2000) show a mortality rate of 33.2 percent, which is up from the baseline of 31.2 percent (1995-1996). Many complex variables may have contributed to the survival rate, including the gradual phased-in efforts in this area and the possible change in concomitant diseases. Further, the age distribution of the Medicare population has increased, which could require risk adjustment. No clear explanation exists for these disappointing trends.

We will continue to report our results for this goal through FY 2002, but we are discontinuing this goal beginning in FY 2003. We will continue to encourage and monitor research in this area to determine what may be causing these disappointing trends. The FY 2001 data is expected in June 2003.

Increase the percentage of Medicare beneficiaries age 65 years and older who receive an annual influenza (flu) vaccination and a lifetime vaccination for pneumococcal.

Complications arising from influenza and pneumococcal disease kill more than 30,000 people a year in the United States and result in more deaths per year than all other vaccine-preventable diseases combined. For persons age 65 or older, the Advisory

Committee on Immunization Practices and other leading authorities recommend an annual vaccination for influenza (flu) and a lifetime vaccination for pneumococcal.

The FY 2002 targets are to achieve a vaccination rate of 72 percent for flu and 66 percent for pneumococcal. Data will not be available until the end of 2003. Our FY 2001 targets were to increase annual influenza vaccination rates to 72 percent and lifetime pneumococcal vaccination rates to 63 percent. The 1994 baselines were 59 percent for flu and 24.6 percent for pneumococcal pneumonia. We are still awaiting final data for our FY 2001 goal based on the Medicare Current Beneficiary Survey data.

Increase the percentage of Medicare beneficiaries age 65 years and older receiving a biennial mammogram.

A mammogram is a safe, low-dose x-ray of the breast and is the most effective means of detecting breast cancer while it is still in an early, treatable stage. Since older women face a greater risk of developing breast cancer than younger women, CMS efforts to encourage regular mammograms is critical to reducing breast cancer among women of Medicare age.

We exceeded our FY 2001 target to increase biennial mammography rates for women age 65 years and older to 51 percent. Based on the National Claims History File, we achieved 51.6 percent. Our 1997-1998 baseline for this goal was 45 percent. We expect to receive data about whether we reached our FY 2002 target of 52 percent in August 2003.

Increase the rate of diabetic eye exams.

Diabetes is another highly prevalent condition in the Medicare population, and many complications of the disease, such as blindness, can be prevented or delayed with appropriate monitoring or treatment. This goal is to increase special eye exams given biennially for our diabetic beneficiaries in order to prevent a form of blindness associated with this disease. The baseline from the National Claims History File is 67.8 percent (1997–1999). We surpassed our FY 2001 target of 68.3 percent by reaching 68.9 percent. Data for our FY 2002 target of 68.6 percent is expected Spring 2003.

Decrease the prevalence of restraints in nursing homes.

Reducing the use of physical restraints is one of our major quality initiatives. Achieving low prevalence of physical restraint use is an accepted indicator of quality of care and considered a proxy for measuring quality of life for nursing home residents. The use of restraints can cause incontinence, pressure sores, loss of mobility, and other morbidities. The FY 2001 target to decrease the prevalence of restraints in nursing homes to 10 percent was reached successfully. In FY 2002, the target was again set at 10 percent. Final data is expected in March 2003.

Decrease the prevalence of pressure ulcers in nursing homes.

The development of pressure ulcers is an undesirable outcome that can be prevented in most nursing home residents, except in those whose clinical condition impedes the

prevention of pressure ulcer development. Reduction of facility-acquired pressure ulcers remains a high priority of CMS.

We are developing a program to educate providers how to more accurately assess and code residents' conditions, including pressure ulcers. We are also developing protocols, including onsite audit procedures, to assess the accuracy of nursing homes' Minimum Data Set assessments. Additionally, CMS has convened a panel of national clinical experts in pressure sore treatment and prevention to help CMS revise the guidelines and investigative protocols used by surveyors, and to improve surveyor training. The FY 2001 target was to decrease the prevalence of pressure ulcers in nursing homes to 9.6 percent; however, our performance was 10.5 percent. We expect to receive data on whether our FY 2002 target of 9.5 percent was reached in March 2003.

Decrease the number of uninsured children by working with States to implement the State Children's Health Insurance Program and by enrolling children in Medicaid.

The SCHIP makes an unprecedented investment to improve the quality of life for millions of vulnerable, uninsured, low-income children. States were given the option to expand their Medicaid program, establish a separate SCHIP, or use a combination of both. The CMS goal is to increase the number of children (up to age 19 for SCHIP; age 21 for Medicaid) who are enrolled in regular Medicaid or SCHIP by one million over the previous year's level. As of FY 2001, there were approximately 27.1 million children enrolled in SCHIP and Medicaid. Due to the overwhelming support for the program, we expect to increase enrollment by 1 million in FY 2002. We expect FY 2002 data by early 2003.

Increase the percentage of Medicaid 2-year-old children who are fully immunized.

Three groups of States, staggered over four years, will develop State-specific baselines, methods, and 3-year targets to increase childhood immunization rates for their States' Medicaid 2-year olds. All 16 Group I States have completed development of their methodologies, baselines, and 3-year targets. For FY 2001, 15 of the 16 have reported on their progress; the final State will report in January 2003. For FY 2002, 5 of the 16 States reported their second remeasurement.

The ten Group II States made excellent progress during their developmental period. These States have defined their State-specific methodologies and all have set their baseline and 3-year target rates. Two of the 10 States reported their first remeasurement for FY 2002. Recruitment efforts for the final group of States (Group III) have been successful and these States are working on defining their State-specific measures during their developmental period.

Improve satisfaction of Medicare beneficiaries with the health care they receive.

Our FY 2002 target of directing efforts to improve beneficiary satisfaction in both managed care (MC) and FFS was met by continuing to collect and share Consumer Assessment Health Plans Surveys (CAHPS) information from beneficiaries with health

plans, and QIOs and beneficiaries. Our measures, set on baselines from CY 2000, include achieving targets by CY 2004 of 93 percent (MC) and 95 percent (FFS) of beneficiaries for access to care, and 86 percent (MC) and 85 percent (FFS) of beneficiaries for access to a specialist. In order for the increases to be statistically significant, these are long-term targets with reporting due at the end of the 5-year period.

Strategic Goal
Foster Appropriate and Predictable Payments and High Quality Care

Sustain Medicare payment timeliness consistent with statutory floor and ceiling requirements.

We will continue to maintain payment timeliness performance at a level that meets the statutory requirement of Medicare intermediaries and carriers who must pay 95 percent of clean electronic media claims between 14 and 30 days from the date of receipt. We exceeded our FY 2002 target (intermediaries equal 99.7 percent; carriers equal 99.5 percent).

Develop new Medicare payment systems in fee-for-service and Medicare + Choice.

This goal was designed to measure our progress towards the development of additional payment systems in FFS and M+C. We met our FY 2002 goal to implement a prospective payment system for inpatient rehabilitation facilities. A revised risk adjustment model has been selected that incorporates both inpatient and ambulatory data.

Strategic Goal
Promote Understanding of CMS Programs Among Beneficiaries, the Health Care Community, and the Public

Improve effectiveness of dissemination of Medicare information to beneficiaries.

We place a high priority on educating our beneficiaries about Medicare program options and provisions. This performance goal and the following goal measure our efforts to educate Medicare beneficiaries. We expect to yield positive results for both of these goals through the following CMS efforts: national media campaigns, phone service availability for 1-800-MEDICARE, web-based capabilities to help consumers compare health plan choices, and a publicity campaign on the new choices and new ways to obtain information.

With clear baselines in place, we continue to track our beneficiary education efforts toward our 5-year target for beneficiary accessibility and understanding of educational

efforts regarding the M+C program. Our goal is that by FY 2004, 77 percent of beneficiaries (a 10 percent increase over FY 1999) will report that the information they received answered their questions and 57 percent (also a 10 percent increase over FY 1999) will know that most people covered by Medicare can select from among different health plan options within Medicare.

Improve beneficiary understanding of basic features of the Medicare program.

Our goal is to improve beneficiary awareness of (1) the core features of the Medicare program and (2) the CMS sources available to obtain additional information. We completed all our targeted actions necessary to design and field survey questions to measure our efforts in these areas. We expect to meet our goal for FY 2002 of setting baselines and targets by early 2003 once the analyzed survey data is available.

Improve effectiveness of dissemination of Medicare information to beneficiaries in fee-for-service through implementation of the Medicare Summary Notice.

National implementation of the Medicare Summary Notice (MSN) is expected to improve the effectiveness of information for beneficiaries enrolled in the FFS program. Because this monthly information will be in a more understandable format than previous multiple notices, it is also expected to be easier for beneficiaries to spot inconsistencies or instances of potential fraud. In FY 2002, CMS reached its goal of national implementation of MSN.

Improve Medicare's administration of the beneficiary appeal process.

The appeal process is a critical safeguard available to all Medicare beneficiaries, which allows them to challenge denial of service. The 2002 target for this goal was developmental. In FY 2002, CMS planned to issue an Operational Policy Letter with instructions for the Medicare +Choice Organizations (M+COs) to begin reporting appeals data. In response to industry concerns however, CMS reassessed the need to collect data at the MCO level. The FFS data collection is currently being reevaluated to determine data needs mandated by the Benefits Improvement and Protection Act (BIPA) of 2000. We are also considering the benefit of a system that can use both FFS and M+C data.

Increase awareness about the opportunity to enroll in the Medicare Savings Programs.

Although Medicare provides beneficiaries with a basic set of health benefits, the beneficiaries are still responsible for out-of-pocket premiums, deductibles, and co-insurance. These costs can be prohibitive for many beneficiaries, particularly for the approximately 12 percent who do not have private or public supplemental insurance. This performance goal will seek to increase awareness of State programs that can assist low-income Medicare beneficiaries with their Medicare cost-sharing expenses. Initially this goal will focus on individuals who are eligible for the Qualified Medicare Beneficiary and Specified Low Income Medicare Beneficiary programs. The target for FY 2002 is to develop a baseline and set future targets to increase awareness. We will receive this information in early 2003.

Strategic Goal
Promote the Fiscal Integrity of CMS Programs and be an Accountable Steward of Public Funds

Maintain CMS's improved rating on financial statements.

With one of the largest budgets in the Federal government, CMS has a special obligation to ensure that we spend each dollar, whether for benefits or administration, as wisely as possible. In FY 1999, FY 2000, and FY 2001, CMS received an unqualified audit opinion. We have continued to meet our target of obtaining an unqualified opinion on the FY 2002 financial statements.

Reduce the percentage of improper payments made under the Medicare fee-for-service program.

The purpose of this goal is to continue to reduce the percentage of improper payments made under the Medicare FFS program. One of our key goals is to pay claims properly the first time. This means paying the right amount to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. Paying claims right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars. We have virtually cut the Medicare FFS error rate in half over the past few years. In FY 2000 we achieved a Medicare FFS error rate of 6.8 percent. We continued this successful trend of reducing the error rate by achieving a 6.3 percent level in FY 2001 and FY 2002.

Increase Medicare Secondary Payer (MSP) credit balance recoveries and/or decrease recovery time to recoup dollar recoveries.

Medicare Secondary Payer (MSP) activities ensure that payment for health care services for beneficiaries is made by the appropriate payer. MSP activity attempts to collect timely and accurate information on the proper order of payers to ensure that Medicare pays only for those claims where it has primary responsibility. We met our FY 2002 goal, which is focused on developing improved processes and controls for the credit balance recovery process, to be utilized by the contractors to ensure consistency and timely recoveries.

Develop and implement methods for measuring program integrity outcomes.

We are developing better methods to measure fraud, waste, and abuse in the Medicare program. For FY 2001, CMS implemented a provider compliance rate (PCR) to measure the appropriateness of claims submitted prior to their payments. In addition, CMS developed a Comprehensive Error Rate Testing (CERT) program that will produce contractor, provider, and benefit specific error rates. The error rates can be aggregated to produce national level estimates similar to the CFO audit Medicare FFS error rate, but with greater

precision. Both PCR and CERT are being implemented simultaneously in several phases. We did not meet our FY 2002 target to develop a model fraud rate program.

Assist States in conducting Medicaid payment accuracy studies for the purpose of measuring and ultimately reducing Medicaid payment error rates.

We are committed to assisting interested States in developing methodologies and conducting pilot studies to reduce Medicaid payment error rates. The FY 2002 target was to conduct a pilot payment accuracy study working with nine States. The data from these studies would be used to help refine payment accuracy measurement methodologies and assess the feasibility of constructing a single methodology usable by all States. No accepted methodology for Medicaid payment accuracy measurement now exists and only a handful of States have done work in this area. The FY 2002 goal was met as nine States developed payment accuracy methodologies as part of their participation in the pilot study.

Improve the management of the survey and certification budget development and execution process.

Our goal to improve the survey and certification budget process moved CMS from the "cost" based approach to a "price" based methodology, which uses national standard measures of workload and costs to project individual State workloads and budgets. We analyzed the combined national average survey times for long-term care facilities. Any State that exceeded the combined national average survey time for long-term care facilities by 15 percent or more was provided an FY 2002 base budget that assumed the FY 2001 funding level. All other States received a FY 2002 base budget increase that did not exceed RO State budget recommendations.

We met our FY 2002 target to allocate the FY 2002 budget increase to the State survey and certification budget using a price-based methodology. Survey quality performance measures to enhance the survey process were communicated to ROs and States in FY 2002.

Increase referral of eligible delinquent debt for cross servicing.

Our goal was to refer 100 percent of all eligible delinquent debt in compliance with the Debt Collection Improvement Act of 1996. Through the end of FY 2002, CMS referred over $5.5 billion in delinquent debt. However, due to the various manual processes used to track and report Medicare debt, the referral process was more time consuming and labor intensive than originally anticipated and therefore we modified our goal to 80 percent. We referred about 90 percent of our eligible delinquent debt by the end of the fiscal year with the balance to be referred in FY 2003.

Assess program integrity customer service.

The CMS is developing a goal to measure and ultimately improve customer satisfaction with the manner in which our program integrity (PI) activities are conducted. This goal focuses on our PI activities with respect to two distinct groups: the provider community and the beneficiary community.

The provider community interacts with CMS and its contractors in many ways. Many providers view the enrollment process as burdensome because of the amount of information that must be supplied. Providers have voiced concern that they do not receive consistent feedback from CMS and its contractors regarding billing issues. They are also concerned that simple billing errors can result in criminal findings. Part of the aim of this goal is to ensure that providers who are subjects of PI-related reviews are satisfied with the manner in which their cases were handled, even though they may not be satisfied with the outcome.

The CMS, in partnership with the American Association for Retired Persons (AARP), has encouraged beneficiaries to be aware of services billed on their behalf and to report any instances of suspected fraud. This goal will strive to ensure that beneficiary contacts with CMS and its contractors are handled in a courteous, professional, and attentive manner.

A survey of providers and beneficiaries was conducted in FY 2002. Targets and a baseline are being developed from these data.

Improve the provider enrollment process.

The purpose of this goal is to improve the certified provider enrollment process at the Medicare contractors. We need to make sure that Medicare contractors only enroll providers and suppliers who are qualified and that only legitimate individuals and entities receive the right to participate in the Medicare program.

During FY 2002, we created a streamlined and more uniform process of revalidating applications from certified providers for Medicare that will continue to promote the type of payment safeguards we implemented in 1996-1997 with the first nationally standardized enrollment application process. Our target for FY 2002 was to develop the Provider Enrollment Chain Ownership System (PECOS), implement the revised CMS-855 enrollment form, and issue a regulation pertaining to establishing and maintaining billing privileges. The PECOS will provide CMS and its contractors the ability to obtain a complete history of any provider or supplier that has or had a business relationship with the Medicare program and the role or roles the individual or organization played in that relationship (e.g., physician, owner, manager, billing agent, etc.). We expect to determine the success of meeting this goal in early 2003.

Strategic Goal
Foster Excellence in the Design and Administration of CMS Programs

Process Medicare+Choice organization elections in compliance with the BBA beneficiary election provisions.

For FY 1999 through FY 2001, this performance goal measured the timeliness of CMS systems' processing of Medicare beneficiary enrollment transactions received from M+COs as specified by the BBA. The FY 2002 performance goal measured the processing

of enrollment and disenrollment transactions received from M+COs in compliance with the beneficiary election provisions of the BBA effective in 2002. Due to the passage of the Bioterrorism Preparedness Act of 2001, the implementation of the lock-in provisions has been statutorily delayed until FY 2005, so this goal could not be achieved in FY 2002 and has been discontinued.

Improve CMS's information systems security.

As CMS broadens the scope of its on-line activity with increased numbers of business partners and technological complexity, the protection of confidential information becomes even more critical. We are committed to fulfilling our stewardship responsibilities for the information contained in our data systems and transported across our networks.

In FY 2002, CMS's goal was to achieve zero material weaknesses in the electronic data processing (EDP) portion of the FY 2002 CFO audits. In addition, evaluations of the highest risk Medicare contractors' security profiles against a comprehensive baseline of security requirements were completed. Application of the baseline to the CMS business partners has begun. The CMS strategy is to complete the evaluation process of all other Medicare contractors over the next three to four years and to close the gaps identified. Lastly, an intrusion detection capability was implemented in April 2002.

Develop and implement an information technology architecture.

We are developing an integrated, enterprise-wide Information Technology (IT) architecture that is aligned with CMS strategic business objectives as required by the Clinger-Cohen Act of 1996. The IT architecture will document the relationships between CMS business and management processes. Its purpose is to ensure that IT requirements are aligned with the business processes that support the CMS mission and that a logically consistent set of policies and standards is developed to guide the engineering of CMS IT systems. In FY 2002, CMS developed eight configuration templates or System Design Reference Models (SDRMs) for use in system development life cycle (SDLC) efforts. Projects have begun using the SDRMs in their SDLC activities. We are continuing architectural development through a segmented approach. In addition, workgroups were established in FY 2002 to develop IT policies and procedures, and two policies have been developed and promulgated. Policies in 15 remaining areas are being drafted.

Increase the use of electronic commerce/standards in Medicare.

We are performing ongoing work with the HIPAA electronic standards development for the health care environment. In FY 2001, we began implementing HIPAA Electronic Data Interchange (EDI) standards. We are consulting with Medicare technical staff within CMS and the Medicare contractor community to develop a baseline and target. Programming and preliminary testing for implementation of the HIPAA claim standard was completed in

FY 2001. However, implementation was delayed into 2003 due to project reprioritization and limitation of contractor programming hours.

The targets for the FY 2002 goal were to: maintain Electronic Media Claim levels of 97 percent for intermediaries and 80 percent for carriers; complete the implementation and testing at Medicare contractor sites of the HIPAA EDI standards for electronic claims and coordination of benefits, and the electronic remittance advice; and begin the implementation activities for the eligibility inquiries and response, and claims status inquiry and response transactions. We met our FY 2002 target.

Improve CMS oversight of Medicare fee-for-service contractors.

Medicare FFS contractors are paid to process claims and administer benefit outlays. Contractors also handle appeals; respond to inquiries from providers and beneficiaries; enroll, educate, and train providers and suppliers; educate and assist beneficiaries; and perform other responsibilities on behalf of CMS. In an effort to improve performance and oversight of these contractors, CMS has established several performance objectives in this area. Through the use of performance information to guide our contractor oversight activities, we are looking forward to continued improvement. Better oversight can be obtained by using a standardized, uniform evaluation process, which is under development. In FY 2002, CMS continued to build on its progress in developing this goal.

Improve beneficiary telephone customer service.

A recent change in our priorities and the strategy for telephone customer service required a redirection of funding from the national caller satisfaction survey to a pilot operation in Pennsylvania (beneficiaries calling a single 800 number) in early FY 2002. This important pilot is a model for how CMS will handle calls in the future, and the future focus of this goal will track the nationwide implementation of this toll free number.

The CMS also made developing and implementing a standard desktop for customer service representatives at contractor call centers one of its highest priorities in telephone delivery. Scheduled to be rolled out to the call centers during FY 2003–2004, the desktop will result in significant improvements in the call centers by increasing the consistency and accuracy of responses to beneficiary inquiries, ultimately increasing their satisfaction with the telephone interaction. Since CMS refocused its priorities, the caller satisfaction and accessibility measures have been discontinued at this time. Thus, the FY 2002 target to complete the data collection and set baseline targets was only partially met due to our refocused approach.

Improve CMS's workforce planning.

To meet the rising challenge of maintaining a workforce with the specific skills necessary to accomplish our goals, and consistent with the President's Management priorities, CMS is instituting a systematic approach to assessing and addressing skills and knowledge needs. In FY 2000, CMS developed a competency catalogue of skills and

knowledge required to accomplish our functions. This catalogue was used in FY 2001 to inventory current employee competencies.

Since the skills inventory was taken, CMS has been implementing strategies to address the gaps in seven targeted knowledge and skill areas. The level of skill or knowledge will be increased by strategic activities to recruit, develop, retain, and/or re-deploy employees. These activities will be evaluated to determine their effectiveness in increasing knowledge or skills.

The CMS met its FY 2002 target to build an automated workforce planning system based on work roles. Having this prototype system available will help CMS determine whether or not to move forward with building a CMS-specific workforce planning system or to use tools specified by the Office of the Secretary as part of the "One HHS" consolidation. If a decision is made to move forward with a CMS system, completion is expected in FY 2003. Full implementation, in FY 2004, will give CMS data on knowledge and skill gaps that can be tracked over time.

Strategic Goal

Provide Leadership in the Broader Health Care Marketplace to Improve Health

Provide to States linked Medicare and Medicaid data files for dually eligible beneficiaries.

This goal was designed to provide a complete picture of Medicare and Medicaid service use and expenditures. Individuals who are dually eligible for Medicare and Medicaid are an important and growing segment of beneficiaries. In 2002, there were approximately 7 million individuals dually eligible for Medicare and Medicaid. Although dually eligible beneficiaries represent about 17 percent of the Medicare population, they account for 30 percent of total Medicare expenditures. We met our goal for FY 2002 by making Medicare use data available to all 50 States and 6 Territories.

Assess the relationship between CMS research investments and program improvements.

The purpose of CMS research program is to provide CMS and the health care policy community with objective analyses and information to develop, test and implement new health care financing policies and to evaluate the impact of CMS programs on its beneficiaries, providers, States, and other customers and partners. A regular systematic review and assessment of CMS research program is important to ensure that CMS beneficiaries obtain maximum benefits from research and development spending. Our performance on this goal is measured using a formal annual internal assessment that is reviewed and evaluated by external experts. In FY 2001, we met our goal to perform an internal assessment and an external review. We anticipate completing the internal assessment and external review for FY 2002 by early 2003.

Sustain improved laboratory testing accuracy.

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) strengthened quality performance requirements under the Public Health Service Act and extend these requirements to all laboratories that test specimens derived from humans. Under CLIA, CMS will continue its partnership with the States to certify and inspect laboratories that test specimens from the human body for health purposes. The CMS performance goal is to sustain improved laboratory testing accuracy by having 90 percent of laboratories enrolled in proficiency testing (PT) with no failures and having 95 percent of laboratories enrolled and participating in PT. We surpassed our CY 2001 targets by having 92.5 percent of laboratories enrolled in PT with no failures, and by having 96.4 percent of laboratories enrolled and participating in PT. We expect to receive CY 2002 data in March 2003, and based on the performance we have seen thus far, we anticipate continued success.

FINANCIAL ACCOMPLISHMENTS AND STATEMENT HIGHLIGHTS

For the fourth consecutive year, we received an unqualified audit opinion on our financial statements. We continue to meet our goals to achieve an unqualified opinion from the auditors, indicating that our financial statements are fairly presented in all material respects and to improve our internal controls and systems. Our strategic vision for financial management is: To develop and maintain a strong financial management operation to meet the changing requirements and challenges of the twenty-first century as we continue to safeguard the assets of the Medicare trust funds. To accomplish this vision, we follow several financial management initiatives, projects, and activities to improve financial reporting and contractor oversight so that CMS management and other decision makers have reliable and accurate financial information. All of our financial management efforts are focused on meeting this challenge.

Chief Financial Officer Comprehensive Plan and Project Plans

We updated our previous comprehensive plan and issued the ***Chief Financial Officer FY 2002 Comprehensive Plan for Financial Management.*** The plan supports our strategic vision by outlining the activities necessary to ensure that we meet our responsibilities to our nation's citizens in establishing a strong and effective financial operation at CMS. It contains 8 goals and 24 initiatives to achieve our strategic vision. The four key financial management objectives of our plan are to: (1) improve financial reporting, guidance, and oversight by providing timely, reliable, and accurate financial information that will enable CMS managers and other decision makers to make timely and accurate program and administrative decisions, (2) design and implement effective financial management systems that comply with the Federal Financial Management Improvement Act

(FFMIA), (3) improve debt collection and internal accounting operations, and (4) validate key financial data to ensure its accuracy and reliability.

We used project plans to measure our progress in achieving the goals and initiatives in the comprehensive plan. The project plans identified the milestones for achieving the Comprehensive Plan goals and initiatives, as well as the detailed activities that support the milestones. Each goal and initiative has a project leader, who reports on their progress monthly to the CFO and the Deputy CFO. Project management is essential to any successful business and CMS has endorsed project planning enthusiastically.

CFO Audit

We received our first unqualified audit opinion on our financial statements in FY 1999. While obtaining an unqualified opinion remains an important goal, we recognize that further efforts are necessary to continue financial management improvements. We have taken steps to improve internal controls and the underlying financial reporting processes to ensure that we can generate accurate financial data on an on-going and timely basis. However, our auditors continue to have concerns over many aspects of contractor financial reporting. One of the major issues remaining is the status of accounts receivable, most of which are maintained on our behalf by our fiscal intermediaries (FI) and carriers. These organizations, commonly referred to as Medicare contractors, have contracted with CMS to administer the day-to-day operations of the Medicare program. They pay claims, audit provider cost reports, and establish and collect overpayments. Because the systems used by the Medicare contractors have not always produced data that were adequately supported, our auditors have had difficulty validating their accounts receivable balances.

Accounts Receivable

To continue receiving an unqualified opinion, we recognize that our financial statements have to properly reflect accounts receivable at their true economic value based on provisions provided within the Office of Management and Budget Circular A-129, ***Managing Federal Credit Programs.*** Medicare accounts receivable consist primarily of provider and beneficiary overpayments, and Medicare Secondary Payer (MSP) receivables of paid claims that we subsequently determined that Medicare should have been the secondary rather than the primary payer.

While we have made significant improvements in financial reporting, our auditors continue to report a material weakness in the Medicare accounts receivable area. Our long-term solution to this material weakness is the Healthcare Integrated General Ledger Accounting System (HIGLAS). The HIGLAS will provide CMS with an integrated financial management system that conforms to government-wide requirements and will strengthen management of Medicare accounts receivable. Until this system is implemented, we will continue projects and activities aimed at compensating for the lack of a modernized system.

Revised Reporting Policy

During FY 2002, we continued a major initiative to revise and issue Medicare contractor financial reporting instructions. These instructions include policies regarding the definition of an accounts receivable, the treatment of unfiled cost reports and allowance for uncollectible accounts, and recognizing and reporting non-MSP and MSP currently not collectible (CNC) debt. In addition, these revisions included the reformatting of financial reports to enable Medicare contractors, CMS central office (CO), and ROs to provide more detailed financial data.

Adjustments to Previously Reported Receivables

In addition to revising policies, we continued to use independent certified public accountants (CPAs) as consultants to review Medicare contractor accounts receivable balances in order to validate the receivable amounts reported to CMS and the adequacy of their internal controls. For FY 2002, the consultants conducted reviews at 15 Medicare contractors, which comprised about 64 percent of the accounts receivable balance reflected in last year's financial statements. Additionally, the scope of these reviews included the timely implementation of Medicare contractors' financial management corrective action plans (CAPs).

The consultants' reviews disclosed a total of $285 million errors ($208 million non-MSP and $77 million MSP) resulting in the accounts receivable being overstated by $61.6 million ($25 million non-MSP and $36.6 million MSP). While there is clearly room for improvement, these amounts continue to indicate significant progress and reflect our enduring commitment to generate accurate financial statements.

Debt Management

We collect the majority of our debt because most overpayments are recognized timely, thus allowing future claims to be offset against current overpayments. Debts that are 181 days delinquent are subject to the Debt Collection Improvement Act (DCIA). Under the DCIA, Federal agencies are required to refer debts to the Treasury Offset Program (TOP) and to a designated debt collection center (DCC) for cross-servicing. Debts referred to the TOP are housed in the National Interactive Database and matched to Federal payments for potential offset. Debts referred to a DCC for cross-servicing can have a variety of collection activities, including sending additional demand letters, referring debts to the TOP, referring debts to private collection agencies, negotiating repayment agreements, and eventually referring some debts to the Department of Justice for litigation, if necessary. The HHS Program Support Center (PSC) serves as the DCC for all CMS debts. The majority of all CMS debts (MSP and non-MSP) are referred to Treasury, via the PSC, for cross-servicing and referral to TOP.

Our debt referral process encompasses all Medicare contractors, CO, and ROs, who forward demand letters to the delinquent debtors and input the debt information into

our Debt Collection System (DCS) to refer the debt electronically to the PSC and Treasury. During FY 2002, we referred approximately $1.4 billion of delinquent debt to the PSC and Treasury for cross-servicing and TOP. This brought our total gross delinquent debt referred to the PSC and Treasury to approximately $5.5 billion by the end of FY 2002, which is about 90 percent of the total net eligible to be referred. Our ultimate goal is to have 100 percent of our eligible delinquent debt referred for cross-servicing and TOP by the end of the second quarter of FY 2003.

Medicare Contractor Oversight

Medicare contractors administer the day-to-day operations of the Medicare program by paying claims, auditing provider cost reports, and establishing and collecting overpayments. As part of these activities, Medicare contractors are required to maintain a vast array of financial data. Due to the materiality of this data, we must have assurances as to its validity and accuracy.

In FY 2001, the financial statement auditors reported that CMS did not clearly delineate the roles and responsibilities of CO and RO staff for the financial oversight of its Medicare contractors. As a result, CMS did not perform certain procedures to help ensure that financial information provided by the contractors was reliable, accurate, and complete.

To address these concerns, we created workgroups comprised of CO and RO consortia staff responsible for addressing four key areas identified by auditors: follow up on CAPs, reconciliations of funds expended to paid claims, trend analysis, and internal controls. The objectives of each workgroup are to clearly define CO and RO roles and responsibilities, as well as develop the national strategic plans to strengthen our Medicare contractor financial management oversight in these areas.

Corrective Action Plans

The annual CFO audits have identified financial management and electronic data processing (EDP) weaknesses that limit our ability to effectively manage the Medicare and Medicaid programs. Correcting these deficiencies is essential to demonstrate our commitment to improve financial management and internal controls. Therefore, audit resolution is a top priority at CMS. Medicare contractors, ROs, and CO components are required to prepare a CAP, which describes activities to correct prior year findings, for all deficiencies identified. Quarterly updates to the CAPs are also required. The CAPs (and their updates) are reviewed by CO for adequacy.

During FY 2002, we created a CAP Workgroup that is responsible for developing policies and procedures for overseeing Medicare contractors' reporting and implementation of CAPs. The workgroup issued final manual instructions that required the submission of a "Universal CAP Report" by Medicare contractors that receive various financial management audits that are performed by the OIG, GAO, hired external CPA firms, as well

as CMS RO and CO staff. The Universal CAP Report standardizes the format of the Medicare contractors' CAPs submissions, and facilitates CMS's monitoring responsibilities of these reports. Training on these new instructions was provided during our annual CFO training conferences. Furthermore, we hired consultants to develop a CAP tracking system that will enable us to monitor the progress at which the Medicare contractors are implementing their CAPs.

We also utilized consultants to follow up on contractors' CAPs during the Statement on Auditing Standards (SAS) 70 audits and accounts receivable consulting reviews that were performed in FY 2002. Also, RO systems security staff visited Medicare contractors to ensure that EDP problems were corrected.

CMS-1522 Reconciliations

On a monthly basis, Medicare contractors perform a reconciliation of their CMS-1522 Funds Expended Report to their paid claims tapes. Although contractors are required to submit this reconciliation to CMS each month, the financial statement auditors continue to identify this area as a material weakness during the annual CFO audit.

To address this weakness, we created the CMS-1522 Cash Reconciliation Workgroup that has been tasked to develop policies and detailed procedures that will require Medicare contractors to reconcile, on a monthly basis, total funds expended by CMS to the corresponding Medicare claims that have been submitted and paid. Through a partnership with OIG, CMS provided Medicare contractors a better understanding of these reconciliations by providing training in this area during our annual CFO training conferences. The workgroup is drafting detailed contractor instructions on the reconciliation process and expects to issue them during FY 2003. Additionally, the 1522 Reconciliation Workgroup finalized a review protocol that we will use to ensure this reconciliation is performed. During FY 2002, the workgroup provided training to CMS RO and CO staff on the final protocol, and selected and performed reviews at six Medicare contractor locations.

Trend Analysis

During FY 2002, we continued to enhance our analytical tools to perform more expansive trend analysis procedures of critical financial related data, specifically accounts receivable and quarterly financial statements. We created the Trend Analysis Workgroup that was tasked with developing policies and procedures for performing trend analysis of key financial data, such as accounts receivable, reported by CMS and our Medicare contractors. These tools provide us the steps necessary to identify unusual variances, potential errors, system weaknesses, or inappropriate patterns of financial data accumulation. Additionally, the tools allow us to perform more extensive data analyses and determine the need for additional actions to ensure that problems are adequately resolved.

To ensure that accounts receivable balances reported are reasonable, the workgroup issued final manual instructions requiring Medicare contractors to perform and submit, on

a quarterly basis, documentation supporting the trend analysis that is performed. Training on these new instructions was also provided to contractors during the annual CFO training conferences. Additionally, the workgroup developed and trained CO and RO staff on a review protocol that we will use to review the adequacy of Medicare contractors' quarterly trending analysis submissions.

Internal Controls

To continue our emphasis on the importance of internal controls in FY 2002, we created the Certification Package on Internal Controls (CPIC) Workgroup that is responsible for developing, creating, and communicating a heightened awareness of internal controls within the Medicare contractor community. The workgroup developed a protocol that we will use to evaluate and assess the Medicare contractors' processes for complying with requirements of the Federal Managers Financial Integrity Act of 1982.

Furthermore, the workgroup finalized manual instructions that provides guidelines and policies to the Medicare contractors to enable them to strengthen their internal control procedures. The workgroup also updated the Medicare contractors internal control objectives. The past several years have confirmed a need for a structured internal control strategy and process for CMS. In the past, we have been criticized for not providing a level of confidence to assure that Medicare contractors had adequate systems of internal controls that were in place and operating efficiently. We believe the procedures and methods set forth in this manual will alleviate the problems and weaknesses for which the program has been cited.

We require all Medicare contractors to submit an annual CPIC on their Medicare operations. In the CPIC, contractors are required to report their material weaknesses and reportable conditions. We require CAPs for all material weaknesses reported in the CPICs. During FY 2002, we also contracted with CPA firms to conduct SAS 70 internal control reviews of 17 Medicare contractors. The reviews indicated that all 17 Medicare contractors reviewed had one or more exceptions. To ensure that the exceptions are properly addressed in a timely manner, we requested the contractors develop and submit CAPs. For FY 2003, we will continue to perform these SAS 70 reviews and monitor contractors' progress for implementing CAPs resulting from these two initiatives.

Financial Management and Reporting

To achieve accurate financial reporting and reliable internal controls, we have identified the following areas as requiring attention.

Budget Execution

We continue to improve our budget execution for the Program Management Appropriation. The Financial Management Investment Board (FMIB), comprised of

senior staff representing each CMS component, recommends allocations of resources in support of our priorities. The CMS Deputy Administrator/Chief Operating Officer makes the final operating plan allocations. In addition, we establish lapse targets for each Program Management allotment, and manage funds aggressively to meet those targets. This ensures available funds are identified timely and allocated to fund our priorities.

Guidance to Medicare Contractors

Medicare contractors provide much of the financial data CMS uses to manage the Medicare program. The importance of ensuring that they are effectively managing resources and reporting accurate financial data cannot be emphasized enough. Therefore, we have continued our efforts to hold Medicare contractors accountable for improved financial management. We do so by requiring them to fix all deficiencies identified by the annual CFO audits and reviews and to report to us on a quarterly basis on their progress.

We also revised and clarified financial reporting and debt collection policies and procedures based on findings from CFO audits, oversight reviews, and SAS 70 internal control reviews. The evaluation of findings resulting from these reviews allows us to perform risk analysis and profiling of Medicare contractors to determine where our resources should be focused and where additional guidance is needed. Additionally, we finalized and issued new guidance requiring Medicare contractors to perform trend analysis procedures of its Medicare accounts receivable balances on a quarterly basis. Our goal is to continue to improve the consistency of information provided by the Medicare contractors.

We conducted two national training conferences for all of the Medicare contractors and ROs. We presented our revised policies and procedures for financial reporting and trend analysis, and also emphasized the importance of debt referral and internal controls documentation. With assurances that data is valid and complete, we have greater confidence in the accuracy and reliability of the financial information reported. We also developed a Medicare contractor financial management manual that will provide guidance on budget preparation and execution, overpayments, debt collection, accounts receivable, contractor financial reports, and enhance contractors' ability to map their internal control environment, and will assist us in the development of training on internal control requirements. The manual is Internet-accessible.

Contractor Performance Evaluations (CPE) Program

As part of our CPE program, reviews of overpayments, audit and reimbursement, and MSP were conducted at selected Medicare contractors. These reviews were either conducted by a team comprised of multi-office staff or a national team of both CO and RO staff. Regardless of the type of team conducting the review, a standard review protocol was used to ensure the reviews are consistent. In addition, the contractors submitted Performance Improvement Plans to address the findings identified.

Financial Reporting

In FY 2002, we continued to improve our financial statement reporting process within CO. All financial data, including data provided by the Department of the Treasury and other Federal agencies, was included in our general ledger. This facilitated the preparation of the financial statements by eliminating manual entries into spreadsheets to determine necessary adjustments. It also provided the auditors with a clearer audit trail.

We completed the initiative of preparing automated formatted financial statements and met our objective to produce and rely upon formatted financial statements directly from the Financial Accounting and Control System (FACS). This will enable the system to produce an audit trail documenting manual adjustments made to accounts that affect the financial statements. We also produced interim financial statements for the quarters ending March 31, 2002 and June 30, 2002, and, for the fifth consecutive year, submitted our financial statements through the automated financial statement system implemented by HHS.

We have also complied with the Department of the Treasury's November 2002 reporting requirement for the Federal Agencies Centralized Trial Balance System (FACTS) II and the February 2002 reporting requirements for FACTS I. We continued to improve the operation of FACS by programming and implementing 155 accounting enhancements. These changes ensured that we met new program and Treasury requirements, as well as improved our administrative and accounting operations.

Medicare Secondary Payer

Our efforts in the MSP area saved the Medicare trust funds approximately $4.3 billion dollars in FY 2002. During FY 2002, we agreed upon a settlement amount of approximately $30 million specific to the recovery of funds from a voluntary medical device recall related to the Sulzer Hip Replacement. We also reached a settlement with Dow Corning in response to breast implant litigation, which will result in the recovery of approximately $10 million.

We are also taking steps to acquire MSP data, in bulk, from our beneficiaries' employers and insurers by entering into voluntary data sharing agreements. In FY 2002, we implemented such agreements with the Blue Cross Blue Shield Association (on behalf of its member plans in the U.S.), Ford, General Motors, and Uniprise (formerly United Health Care). We are also in negotiations with several other employers and insurers.

Other Initiatives

For the past several years, the number of unsettled managed care cost reports has been decreasing. The total backlog of unsettled managed care cost reports at the close of FY 2002 was 139, a decrease of 9 percent from the close of FY 2001. Disallowances resulting from FY 2002 settlement activity amounted to about $34 million. We have historically experienced a rate of return of about 22 to 1. We anticipate those numbers will increase due to significant audit findings. Our most recent information shows for

the first six-month period of FY 2002 a rate of return of 32 to 1. The remaining backlog of unsettled managed care cost reports still represents a challenge to CMS, because these cost reports have critical audit issues that must be resolved with Managed Care Organizations (MCOs). Therefore, it is projected that settlement activity will remain stable in the future fiscal years.

We also made important accomplishments in our administrative payment areas. We continued to pay all of our administrative payments on time in accordance with the Prompt Payment Act. Over 97 percent of our vendor reimbursements and over 99 percent of our travel reimbursements are made electronically.

Healthcare Integrated General Ledger Accounting System

Although our CFO auditors have found that Medicare contractors' claims processing systems are operating effectively in paying claims, they were not designed to meet the requirements of a dual entry, general ledger accounting system. As a result, they do not meet the provisions of the Federal Financial Management Improvement Act (FFMIA) of 1996. Therefore, a key element of our strategic vision is to acquire an FFMIA-compliant financial management system that will include all Medicare contractors. This project is called the Healthcare Integrated General Ledger Accounting System (HIGLAS). As part of this effort, CMS will replace the FACS, which accumulates all of the CMS financial activities, both programmatic and administrative, in its general ledger.

Following the guidance of OMB Circular A-130, ***Management of Federal Information Resources***, we acquired a commercial-off-the-shelf (COTS) product for HIGLAS. IBM (formerly PwC Consulting) is acting as the systems integrator. Its teaming partners, Oracle Corporation and Electronic Data Systems, are providing the financial accounting software and application service provider services, respectively. Implementing an integrated general ledger program will give CMS enhanced oversight of contractor accounting systems and provide high quality, timely data for decision-making and performance measurement.

The HIGLAS project began with a pilot program with one Medicare contractor (Palmetto Government Benefit Administrators) that processes primarily hospital and other institutional claims, and another Medicare contractor (Empire Blue Cross Blue Shield) that processes primarily physician and supplier claims. The pilot phase will reengineer the accounting business process of the Medicare contractors to support the accounting software.

Once completed, the system will be thoroughly tested to ensure it works correctly and can handle the large volume of financial transactions generated by the Medicare program before a final decision is made to install the accounting system for Medicare and all its contractors. Full implementation is projected for the end of FY 2007.

The new system will also strengthen management of Medicare accounts receivable and allow more timely and effective collection activities on outstanding debts. These improvements in financial reporting by CMS and its contractors are essential to retaining an unqualified opinion on our financial statements, meeting the requirements of key federal legislation, and safeguarding government assets.

Financial Statement Highlights

Consolidated Balance Sheet

The Consolidated Balance Sheet presents amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts that comprise the difference (net position). The CMS Consolidated Balance Sheet shows $306.2 billion in assets. The bulk of these assets are in the Trust Fund Investments totaling $271.9 billion, which are invested in U.S. Treasury Special Issues, special public obligations for exclusive purchase by the Medicare trust funds. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. The next largest asset is the Fund Balance with Treasury of $19.2 billion, most of which is for Medicaid and SCHIP. Liabilities of $45.4 billion consist primarily of the Entitlement Benefits Due and Payable of $44.6 billion. The CMS net position totals $260.8 billion and reflects the cumulative results of the Medicare trust fund investments and the unexpended balance for SCHIP.

Consolidated Statement of Net Cost

In FY 2002, the Consolidated Statement of Net Cost shows only a single amount: the actual net cost of CMS operations for the period by program. The three major programs that CMS administers are Medicare, Medicaid, and SCHIP. The majority of CMS expenses are allocated to these programs.

Total Benefit Payments were $407.4 billion for FY 2002. This amount includes estimated improper Medicare payments of $8.2 to $18.4 billion based on an OIG audit. Administrative Expenses were $2.6 billion, less than 1 percent of total net Program/Activity Costs of $384.9 billion.

The net cost of the Medicare program including benefit payments, Quality Improvement Organizations, Medicare Integrity Program spending, and administrative costs, was $231.1 billion. The HI total costs of $148.1 billion were offset by $1.5 billion in premiums. The SMI total costs of $109.0 billion were offset by premiums of $24.4 billion. Medicaid total costs of $150.1 billion represent expenses incurred by the States and Territories that were reimbursed by CMS during the fiscal year, plus accrued payables. The SCHIP total costs were $3.7 billion.

Consolidated Statement of Changes in Net Position

The Consolidated Statement of Changes in Net Position shows the net cost of operations less financing sources other than exchange revenues, and the net position at the end of period. The line, Appropriations Used, represents the Medicaid appropriations used of $149.9 billion, $85.8 billion in transfers from Payments to Health Care Trust Funds to HI and SMI, SCHIP appropriations of $3.7 billion, and Ticket to Work appropriations of $8 million. Medicaid and SCHIP are financed by a general fund appropriation provided by Congress. Employment tax revenue is Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA) for the HI trust fund totaling $152.0 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to Health Care Trust Funds) of $76.7 billion, that matches monthly premiums paid by beneficiaries.

Combined Statement of Budgetary Resources

The Combined Statement of Budgetary Resources provides information about the availability of budgetary resources, as well as their status at the end of the year. The CMS total budgetary resources were $510.1 billion. Obligations of $506.7 billion leave available unobligated balances of $3.4 billion. Total outlays were $497.7 billion. Net outlays to the public were $381.7 billion. The difference between the outlays to the public and the net outlays of $471.7 billion is comprised of $90.0 billion in the Payments to Health Care Trust Funds, which is appropriated from the general fund into the SMI trust fund, then expended as benefit payments; and $26.0 billion relating to collection of premiums.

Consolidated Statement of Financing

The Consolidated Statement of Financing is a reconciliation of the preceding statements. Accrual-based measures used in the Consolidated Statement of Net Cost differ from the obligation-based measures used in the Combined Statement of Budgetary Resources, especially in the treatment of liabilities. A liability not covered by budgetary resources may not be recorded as a funded liability in the budgetary accounts of CMS's general ledger, which supports the Report on Budget Execution (SF 133) and the Combined Statement of Budgetary Resources. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Consolidated Balance Sheet, Consolidated Statement of Net Cost, and Consolidated Statement of Changes in Net Position. A reconciling item has been entered on the Consolidated Statement of Financing.

Required Supplementary Stewardship Information (RSSI)

As required by the Statement of Federal Financial Accounting Standards (SFFAS) Number 10, CMS has included information about the Medicare trust funds—HI and SMI. The RSSI assists users in evaluating operations and aids in assessing the sufficiency of

future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the ***2002 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds***, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds.

Limitations of the Financial Statements

The financial statements have been prepared to report the financial position and results of operations of CMS, pursuant to the requirements of 31 U.S.C. 3515(b) and the Chief Financial Officers Act of 1990 (P.L. 101-576).

While these financial statements have been prepared from CMS's general ledger and subsidiary reports and supplemented with financial data provided by the U.S. Treasury in accordance with the formats prescribed by OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources that are prepared from the same books and records. These statements use accrual accounting, and some amounts shown will differ from those in other financial documents, such as the Budget of the U.S. Government and the annual report of the Boards of Trustees for HI and SMI, which are presented on a cash basis. The statements should be read with the realization that they are for a component of the United States government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation that provides resources to do so. The accuracy and propriety of the information contained in the principal financial statements and the quality of internal control rests with management.

Principal Statements and Notes

CONSOLIDATED BALANCE SHEET
As of September 30, 2002
(in millions)

	FY 2002 Consolidated Totals	FY 2001 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury ***(Note 2)***	$19,182	$17,427
Trust Fund Investments ***(Note 3)***	271,933	243,092
Accounts Receivable, Net ***(Note 4)***	634	554
Other Assets:		
Anticipated Congressional Appropriation ***(Note 5)***	10,399	11,166
Total Intragovernmental Assets	**302,148**	**272,239**
Cash and Other Monetary Assets	375	137
Accounts Receivable, Net ***(Note 6)***	3,612	4,086
General Property, Plant and Equipment, Net	9	12
Other	54	
TOTAL ASSETS	**$306,198**	**$276,474**
LIABILITIES ***(Note 9)***		
Intragovernmental Liabilities:		
Accounts Payable	$224	
Accrued Payroll and Benefits	5	$4
Other Intragovernmental Liabilities ***(Note 7)***	312	698
Total Intragovernmental Liabilities	**541**	**702**
Federal Employee and Veterans' Benefits	10	10
Entitlement Benefits Due and Payable ***(Note 8)***	44,576	40,441
Accrued Payroll and Benefits	56	55
Other Liabilities ***(Note 7)***	212	210
TOTAL LIABILITIES	**45,395**	**41,418**
NET POSITION		
Unexpended Appropriations	14,096	11,564
Cumulative Results of Operations	246,707	223,492
TOTAL NET POSITION	**$260,803**	**$235,056**
TOTAL LIABILITIES AND NET POSITION	**$306,198**	**$276,474**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF NET COST
For the Year Ended September 30, 2002
(in millions)

	FY 2002 Consolidated Totals	FY 2001 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRA Programs		
Medicare *(Includes estimated improper payments of $8.2-$18.4 billion)* ***(Note 10)***	$231,132	$219,357
Medicaid	150,101	130,450
SCHIP	3,662	2,487
Net Cost - GPRA Programs	**384,895**	**352,294**
Other Activities		
CLIA	19	83
Ticket to Work Incentive	9	2
Other	1	2
Net Cost - Other Activities	**29**	**87**
NET COST OF OPERATIONS ***(Note 11)***	**$384,924**	**$352,381**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2002
(in millions)

	Cumulative Results of Operations	Unexpended Appropriations
Beginning Balances	$223,492	$11,564
Prior Period Adjustment ***(Note 12)***	(110)	110
BEGINNING BALANCES, AS ADJUSTED	**223,382**	**11,674**
Budgetary Financing Sources:		
Appropriations Received		247,188
Appropriations Transferred-in/out		(1,050)
Other Adjustments ***(Note 13)***		(4,348)
Appropriations Used	239,368	(239,368)
Nonexchange Revenue ***(Note 14)***	169,828	
Transfers-in/out Without Reimbursement ***(Note 15)***	(976)	
Other Budgetary Financing Sources		
Other Financing Sources:		
Imputed Financing from Costs Absorbed by Others	29	
TOTAL FINANCING SOURCES	**408,249**	**2,422**
NET COST OF OPERATIONS	**384,924**	
ENDING BALANCES	**$246,707**	**$14,096**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENT OF BUDGETARY RESOURCES
For the Year Ended September 30, 2002
(in millions)

	Combined Totals
Budgetary Resources:	
Budget authority:	
Appropriations received	$532,604
Net transfers	(1,050)
Unobligated balance:	
Beginning of period	400
Spending authority from offsetting collections:	
Earned:	
Collected	93
Receivable from Federal sources	(26)
Change in unfilled customer orders:	
Advance received	5
Transfers from trust funds	2,388
SUBTOTAL	**534,414**
Recoveries of prior year obligations	7,256
Temporarily not available pursuant to Public Law	(28,031)
Permanently not available	(3,582)
TOTAL BUDGETARY RESOURCES	**$510,057**
Status of Budgetary Resources:	
Obligations incurred: ***(Note 17)***	
Direct	$506,602
Reimbursable	97
SUBTOTAL	**506,699**
Unobligated balance:	
Apportioned	3,151
Unobligated balance not available	207
TOTAL STATUS OF BUDGETARY RESOURCES	**$510,057**
Relationship of Obligations to Outlays:	
Obligated balance, net, beginning of period	$18,587
Obligated balance, net, end of period:	
Accounts receivable	(1,144)
Undelivered orders	12,552
Accounts payable	6,493
Outlays:	
Disbursements	499,832
Collections	(2,163)
SUBTOTAL	**497,669**
LESS: OFFSETTING RECEIPTS	**25,951**
NET OUTLAYS	**$471,718**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF FINANCING
For the Year Ended September 30, 2002
(in millions)

	Consolidated Totals
RESOURCES USED TO FINANCE ACTIVITIES:	
Budgetary Resources Obligated:	
Obligations incurred	$506,699
Less: Spending authority from offsetting collections and recoveries	9,716
Obligations net of offsetting collections and recoveries	496,983
Less: Offsetting receipts	25,951
NET OBLIGATIONS	**471,032**
Other Resources:	
Imputed financing from costs absorbed by others	29
NET OTHER RESOURCES USED TO FINANCE ACTIVITIES	**29**
TOTAL RESOURCES USED TO FINANCE ACTIVITIES	**$471,061**
RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS:	
Change in budgetary resources obligated for goods, services and benefits ordered but not yet provided	$(451)
Resources that fund expenses recognized in prior periods	44,664
Other resources or adjustments to net obligated resources that do not affect net cost of operations	87,220
TOTAL RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS	**131,433**
TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS	**$339,628**
COMPONENTS OF THE NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD:	
Components Requiring or Generating Resources in Future Periods:	
Accrued Entitlement Benefit costs	$44,576
Increase in annual leave liability	1
Decrease in exchange revenue receivable from the public	749
Other	418
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL REQUIRE OR GENERATE RESOURCES IN FUTURE PERIODS	**45,744**
Components Not Requiring or Generating Resources:	
Depreciation and amortization	4
Other	(452)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT DO NOT REQUIRE OR GENERATE RESOURCES DURING THE REPORTING PERIOD	(448)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD	**45,296**
NET COST OF OPERATIONS	**$384,924**

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity

The CMS is a separate financial reporting entity of HHS. The financial statements have been prepared to report the financial position and results of operations of CMS, as required by the Chief Financial Officers Act of 1990. The statements were prepared from CMS's accounting records in accordance with accounting principles generally accepted in the United States (GAAP) and the form and content specified by the Office of Management and Budget (OMB) in OMB Bulletin 01-09.

The financial statements cover all the programs administered by CMS. The programs administered by CMS are shown in two categories, Medicare and Health. The Medicare programs include:

Medicare Hospital Insurance (HI) Trust Fund

Medicare contractors are paid by CMS to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI trust fund. The CMS payments to managed care plans are also charged to this fund. The financial statements include HI trust fund activities administered by the Department of the Treasury (Treasury). This trust fund has permanent indefinite authority.

Medicare Supplementary Medical Insurance (SMI) Trust Fund

Medicare contractors are paid by CMS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end stage renal disease (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI trust fund. The CMS payments to managed care plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. This trust fund has permanent indefinite authority.

Medicare Integrity Program (MIP)

The Health Insurance Portability and Accountability Act, Public Law 104-191, established the MIP and codified the program integrity activities previously known as "payment safeguards." This account is also called the Health Care Fraud and Abuse Control (HCFAC) Program, or simply "Fraud and Abuse." The CMS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The MIP is funded by the HI trust fund.

Payments to the Health Care Trust Funds Appropriation

The Social Security Act provides for payments to the HI and SMI trust funds for SMI (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). In addition, funds are provided by this appropriation to cover the Medicaid program's share of CMS's administrative costs. To prevent duplicative reporting, the Fund Balance, Unexpended Appropriation, Financing Sources and Expenditure Transfers of this appropriation are reported only in the Medicare HI and SMI columns of the financial statements.

Permanent Appropriations

A transfer of general funds to the HI trust fund in amounts equal to SECA tax credits and the

increase to the tax payment from Old Age Survivors and Disability Insurance (OASDI) beneficiaries is made through 75X0513 and 75X0585, respectively. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989. The amounts reported in FY 2002 are adjustments for late or amended tax returns. The Social Security Amendments of 1994, provided for additional tax payments from Social Security and Tier 1 Railroad Retirement beneficiaries.

The Health programs include:

Medicaid

Medicaid, the health care program for low-income Americans, is administered by CMS in partnership with the States. Grant awards limit the funds that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of the CMS share of States' Medicaid costs. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between approved expenses reported for the period and the grant awards previously issued.

The State Children's Health Insurance Program (SCHIP)

SCHIP, included in the Balanced Budget Act of 1997 (BBA), was designed to provide health insurance for children, many of whom come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The BBA set aside funds for ten years to provide this new insurance coverage. The grant awards, prepared at the beginning of each quarter and amended as necessary, are based on a State approved plan to implement SCHIP. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between approved expenses reported for the period and the grant awards previously issued.

The Ticket to Work and Work Incentives Improvement Program

The Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170, established two grant programs. The Act program provides funding for Medicaid infrastructure grants to support the design, establishment and operation of State infrastructures to help working people with disabilities purchase health coverage through Medicaid. The Act also provides funding for States to establish Demonstrations to Maintain Independence and Employment, which will provide Medicaid benefits and services to working individuals who have a condition that, without medical assistance, will result in disability.

Health Maintenance Organization (HMO) Loan and Loan Guarantee Fund

The HMO Loan and Loan Guarantee Fund was originally established to provide working capital to HMOs during their initial period of operations and to guarantee loans made by private lenders to HMOs. The last loan commitments were made in FY 1983. Direct loans to HMOs were sold, with a guarantee, to the Federal Financing Bank (FFB). The FFB purchase proceeds were then used as capital for additional direct loans. Therefore, the fund operates as a revolving fund. Currently, CMS collects principal and interest payments from HMO borrowers, and, in turn, pays the FFB.

Program Management User Fees: Medicare+Choice, Clinical Laboratory Improvement Program, and Other User Fees

This account operates as a revolving fund without fiscal year restriction. The BBA established the Medicare+Choice program that requires managed care plans to make payments for their share of the estimated costs related to enrollment, dissemination of information, and certain counseling and assistance programs. These user fees are devoted to educational efforts for beneficiaries and outreach partners. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) marked the first

comprehensive effort by the Federal government to regulate medical laboratory testing. The CMS and the Public Health Service share responsibility for the CLIA program, with CMS having the lead responsibility for financial management. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys. Proceeds from the sale of data from the public use files and publications under the Freedom of Information Act (FOIA) are also credited to this fund.

Program Management Appropriation

The Program Management Appropriation provides CMS with the major source of administrative funds to manage the Medicare and Medicaid programs. The funds for this activity are provided from the HI and SMI trust funds, the general fund, and reimbursable activities. The Payments to the Health Care Trust Funds Appropriation reimburses the Medicare HI trust fund to cover the Medicaid program's share of CMS administrative costs (see Note 15). User fees collected from managed care plans seeking Federal qualification and funds received from other federal agencies to reimburse CMS for services performed for them are credited to the Program Management Appropriation.

The cost related to the Program Management Appropriation is allocated among all programs based on the CMS cost allocation system. It is reported in the Medicare and Health columns of the Consolidating Statement of Net Cost in the Supplementary Financial Statement Section.

Basis of Presentation

The financial statements have been prepared to report the financial position and results of operations of CMS, pursuant to the requirements of 31 U.S.C. 3515(b), the Chief Financial Officers Act of 1990 (P.L. 101-576), as amended by the Government Management Reform Act of 1994.

These financial statements have been prepared from the CMS general ledger in accordance with GAAP and the formats prescribed by the OMB Bulletin 01-09. Some amounts shown will differ from those in other financial documents, such as the ***Budget of the U.S. Government*** and the annual report of the Boards of Trustees for HI and SMI, which are presented on a cash basis.

Basis of Accounting

The CMS uses the Government's Standard General Ledger account structure and follows accounting policies and guidelines issued by HHS. The financial statements are prepared on an accrual basis. Individual accounting transactions are recorded using both the accrual basis and cash basis of accounting. Under the accrual method, expenses are recognized when resources are consumed, without regard to the payment of cash. Under the cash method, expenses are recognized when cash is outlayed. The CMS follows standard budgetary accounting principles that facilitate compliance with legal constraints and controls over the use of Federal funds.

The CMS uses the cash basis of accounting in the Medicare program to record benefit payments disbursed during the fiscal year, supplemented by the accrual method to estimate the value of benefit payments incurred but not yet paid as of the fiscal year end. Revenues are also recognized both when earned (without regard to receipt of cash) and, in the case of HI and SMI premiums, when collected. Employment taxes earmarked for the Medicare program are recorded on a cash basis.

The CMS uses the cash basis of accounting in the Medicaid and SCHIP programs to record funds paid to the States during the fiscal year, supplemented by the accrual method to estimate the value of expenses (net of recoveries) not yet reported to CMS as of the end of the fiscal year.

Balance Sheet

The Balance Sheet presents amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts which comprise the difference (net position). The major components are described below.

Assets

Fund Balances are funds with Treasury that are primarily available to pay current liabilities. Cash receipts and disbursements are processed

by Treasury. The CMS also maintains lockboxes at commercial banks for the deposit of SMI premiums from States and third parties and for collections from HMO plans.

Trust Fund Investments are investments (plus the accrued interest on investments) held by Treasury. Sections 1817 for HI and 1841 for SMI of the Social Security Act require that trust fund investments not necessary to meet current expenditures be invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and was adjusted to include an accrual for interest earned from July 1 to September 30.

Accounts Receivable, Net consists of amounts owed to CMS by other Federal agencies and the public. Amounts due are presented net of an allowance for uncollectible accounts.

Medicare Secondary Payer (MSP) Accounts Receivable (A/R) consists of amounts owed to Medicare by insurance companies, employers, beneficiaries, and/or providers for payments made by Medicare that should have been paid by the primary payer. Receipts are transferred to the HI or SMI trust fund upon collection. Amounts due are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is based on past collection experience and an analysis of the outstanding balances.

Medicare Non-MSP A/R consists of amounts owed to Medicare by medical providers and others because Medicare made payments that were not due, for example, excess payments that were determined to have been made once provider cost reports were audited. Non-MSP A/R represent entity receivables and, once collected, are transferred to the HI or SMI trust fund. Amounts due are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is based on past collection experience and an analysis of the outstanding balances.

Cash and Other Monetary Assets are the total amount of time account balances at the Medicare contractor commercial banks. The Checks Paid Letter-of-Credit method is used for reimbursing Medicare contractors for the payment of covered Medicare services. Medicare contractors issue checks against a Medicare Benefits account maintained at commercial banks. In order to compensate commercial banks for handling the Medicare Benefits accounts, Medicare funds are deposited into non-interest-bearing time accounts. The earnings allowances on the time accounts are used to reimburse the commercial banks.

Property, Plant and Equipment (PP&E) are recorded at full cost of purchase, including all costs incurred to bring the PP&E to a form and location suitable for its intended use, net of accumulated depreciation. All PP&E with an initial acquisition cost of $25,000 or more and an estimated useful life of 2 years or greater is capitalized. The PP&E is depreciated on a straight-line basis over the estimated useful life of the asset. Normal maintenance and repair costs are expensed as incurred.

Liabilities

Liabilities represent amounts owed by CMS as the result of transactions that have occurred. In accordance with Public Law and existing Federal accounting standards, no liability is recorded for any future payment to be made on behalf of current workers contributing to the Medicare HI trust fund.

Liabilities covered by available budgetary resources include (1) new budget authority, (2) spending authority from offsetting collections, (3) recoveries of unexpired budget authority, (4) unobligated balances of budgetary resources at the beginning of the year, and (5) permanent indefinite appropriation or borrowing authority.

Liabilities not covered by budgetary resources are incurred when funding has not yet been made available through Congressional appropriations or current earnings. The CMS recognizes such liabilities for employee annual leave earned but not taken, and amounts billed by the Department of Labor for Federal Employee's Compensation Act (FECA) payments. For CMS revolving funds, all liabilities are funded as they occur.

Accounts Payable consists of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables.

Federal Employee and Veterans' Benefits consist of the actuarial portions of future benefits earned by Federal employees and Veterans, but not yet due and payable. These costs include pensions, other retirement benefits, and other post-employment benefits. These benefits programs are normally administered by the Office of Personnel Management (OPM) and not by CMS.

Entitlement Benefits Due and Payable represent Medicare or Medicaid medical services incurred but not paid as of September 30. The Medicare estimate is developed by the Office of the Actuary (OACT) and is based on historical trends of completeness that take into consideration estimated deductible and coinsurance amounts. The estimate represents (1) claims incurred that may or may not have been submitted to the Medicare contractors and were not yet approved for payment, (2) claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (3) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (4) periodic interim payments, and (5) retroactive settlements of cost reports.

The Medicaid amount reported is the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases. This information was provided by the States.

Accrued Payroll and Benefits consist of Workers Compensation (FECA) payments due to the Department of Labor and the estimated liability for salaries, wages, funded annual leave and sick leave that has been earned but is unpaid.

Other Liabilities are the retirement plans utilized by CMS employees; the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS). Under CSRS, CMS makes matching contributions equal to 7 percent of pay. The CMS does not report CSRS assets, accumulated plan benefits, or unfunded liabilities, if any, applicable to its employees. Reporting such amounts is the responsibility of OPM.

Most employees hired after December 31, 1983 are automatically covered by FERS. A primary feature of FERS is that it offers a savings plan to which CMS is required to contribute 1 percent of pay and to match employee contributions up to an additional 4 percent of pay. For employees covered by FERS, CMS also contributes the employer's matching share of Social Security taxes.

Net Position

Net Position contains the following components:

Unexpended Appropriations include the portion of CMS's appropriations represented by undelivered orders and unobligated balances.

Cumulative Results of Operations represent the net results of operations since the inception of the program plus the cumulative amount of prior period adjustments.

Statement of Net Cost

The Statement of Net Cost shows only a single dollar amount: the actual net cost of CMS's operations for the period by program. Under GPRA, CMS is required to identify the mission of the agency and develop a strategic plan and performance measures to show that desired outcomes are being met. The three major programs that CMS administers are: Medicare, Medicaid, and SCHIP. The bulk of CMS's expenses are allocated to these programs. The MIP is included in Medicare. The costs related to the Program Management Appropriation are cost-allocated to all three major components. The net cost of operations of the CLIA program and other programs are shown separately under "Other Activities."

Although the following terms do not appear in the Statement of Net Cost, they are an integral part in the calculation of a program's net cost of operations:

Program/Activity Costs represent the gross costs or expenses incurred by CMS for all activities.

Benefit Payments are payments by Medicare contractors, CMS, and Medicaid State agencies to health care providers for their services.

Administrative Expenses represent the costs of doing business by CMS and its partners.

Exchange Revenues (or earned revenues) arise when a Government entity provides goods and services to the public or to another Government entity for a fee.

Premiums Collected are used to finance SMI benefits and administrative expenses. Monthly premiums paid by Medicare beneficiaries are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Net Cost of Operations is the difference between the program's gross costs and its related exchange revenues.

Statement of Changes in Net Position

In FY 2002 CMS revised the format of the Statement of Changes in Net Position (SCNP) to conform to the format prescribed by OMB Bulletin 01-09. The SCNP reports the change in net position during the fiscal year that occurred in the two components of net position: Cumulative Results of Operations and Unexpended Appropriations. The SCNP comprises the following major line items:

Prior Period Adjustments are either corrections of errors or changes in accounting principles with retroactive effect that increase or decrease net position.

Budgetary Financing Sources display financing sources and nonexchange revenue that are also budgetary resources, as reported on the Statement of Budgetary Resources.

Appropriations Received show the amounts of appropriations received in the current fiscal year.

Budgetary Financing Sources (Other than Exchange Revenues) arise primarily from exercise of the Government's power to demand payments from the public (e.g., taxes, duties, fines, and penalties). These include appropriations used, transfers of assets from other Government entities, donations, and imputed financing.

Appropriations Used and Federal Matching Contributions are described in the Medicare Premiums section above. For financial statement purposes, appropriations used are recognized as a financing source as expenses are incurred. A transfer of general funds to the HI trust fund in an amount equal to SECA tax credits is made through the Payments to the Health Care Trust Funds Appropriation. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989.

Employment Tax Revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under FICA and SECA. Employees and employers were both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contributed the full 2.9 percent of their net income.

Transfers-in/Transfers-out report the transfers of funds between CMS programs or between CMS and other Federal agencies. Examples include transfers made from CMS's Payment to the Health Care Trust Fund appropriation to the HI and SMI trust funds and the transfers between the HI and SMI trust funds and CMS's Program Management appropriation.

Statement of Budgetary Resources

The Statement of Budgetary Resources provides information about the availability of budgetary resources as well as their status at the end of the year. Budgetary Statements were developed for each of the budgetary accounts. In this statement, the Program Management and the Program Management User Fee accounts are combined and are not allocated back to the other programs.

Also, there are no intra-CMS eliminations in this statement. The CMS was required to return the unobligated balance of the indefinite authority appropriated to Medicaid in the last quarter of FY 2001 to the general fund of Treasury.

Unobligated Balances—beginning of period represent funds available. These funds are primarily HI and SMI trust fund balances invested by the Treasury.

Budget Authority represents the funds available through appropriations, direct spending authority, obligations limitations, unobligated balances at the beginning of the period or transferred in during the period, spending authority from offsetting collections, and any adjustments to budgetary authority.

Obligations Incurred consists of expended authority, recoveries of prior year obligations and the change in undelivered orders.

Adjustments are increases or (decreases) to budgetary resources. Increases include recoveries of prior year obligations; decreases include budgetary resources temporarily not available, recissions, and cancellations of expired and no-year accounts.

Statement of Financing

The Statement of Financing is a reconciliation of the preceding statements. Accrual-based measures used in the Statement of Net Cost differ from the obligation-based measures used in the Statement of Budgetary Resources, especially in the treatment of liabilities. A liability not covered by budgetary resources may not be recorded as a funded liability in the budgetary accounts of CMS's general ledger, which supports the Report on Budget Execution (SF 133) and the Statement of Budgetary Resources. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Balance Sheet, Statement of Net Cost and Statement of Changes in Net Position. A reconciling item has been entered on the Statement of Financing, which has been prepared on a consolidated basis, except for the budgetary information used to calculate net obligations (budgetary resources), which must be presented on a combined basis.

Use of Estimates in Preparing Financial Statements

Preparation of financial statements in accordance with Federal accounting standards requires CMS to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from those estimates

Intra-Governmental Relationships and Transactions

In the course of its operations, CMS has relationships and financial transactions with numerous Federal agencies. For example, CMS interacts with the Social Security Administration (SSA) and Treasury. The SSA determines eligibility for Medicare programs, and also allocates a portion of Social Security benefit payments to the Medicare Part B trust fund for Social Security beneficiaries who elect to enroll in the Medicare Part B program. The Treasury receives the cumulative excess of Medicare receipts and other financing sources, and issues interest-bearing securities in exchange for the use of those monies. At the Government-wide level, the assets related to the trust funds on CMS's financial statements and the corresponding liabilities on the Treasury's financial statements are eliminated.

Comparative Data

In accordance with OMB Bulletin 01-09, CMS has presented a comparative Balance Sheet and Statement of Net Cost.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2002, CMS has canceled over $136 million in cumulative obligations to FY 1996 and prior years in accordance with the National Defense Authorization Act of Fiscal Year 1991 (P.L. 101-150). Based on the payments made in FYs 1998 through 2002 related to canceled appropriations, CMS anticipates an additional $1.5 million will be paid from current year funds for canceled obligations.

NOTE 2:

FUND BALANCE WITH TREASURY *(Dollars in Millions)*

FY 2002	Entity Assets Unrestricted	Entity Assets Restricted	Consolidated Total
FUND BALANCES:			
Trust Funds			
HI Trust Fund Balance *(1)*	$159	$3	$162
SMI Trust Fund Balance *(1)*	(251)	3,014	2,763
Revolving Funds			
HMO Loan *(2)*	11		11
CLIA *(2)*	129		129
Appropriated Funds			
Medicaid	5,040		5,040
SCHIP	10,933		10,933
TWI *(2)*	117		117
Other Fund Types			
CMS Suspense Account *(2)*	11		11
Program Management Reimbursables *(2)*	16		16
TOTAL FUND BALANCES	**$16,165**	**$3,017**	**$19,182**
STATUS OF FUND BALANCES WITH TREASURY:			
Unobligated Balance			
Available	$135	$3,017	$3,152
Unavailable	(1,872)		(1,872)
Obligated Balance not yet Disbursed	17,902		17,902
TOTAL STATUS OF FUND BALANCES WITH TREASURY	**$16,165**	**$3,017**	**$19,182**

(1) The restricted portions of the HI and SMI fund balances represent the remaining fund balance in the Payments to the Health Care Trust Funds appropriation, which is allocated to HI and SMI.

(2) These fund balances are reported in the Supplementary Financial Statement section under the "All Others" column of the Consolidating Balance Sheet.

FY 2001	Entity Assets Unrestricted	Entity Assets Restricted	Consolidated Total
Trust Funds			
HI Trust Fund Balance *(1)*	$290	$3	$293
SMI Trust Fund Balance *(1)*	(69)		(69)
Revolving Funds			
HMO Loan *(2)*	10		10
CLIA *(2)*	141		141
Appropriated Funds			
Medicaid	5,462		5,462
SCHIP	11,501		11,501
TWI *(2)*	60		60
Other Fund Types			
CMS Suspense Account *(2)*	16		16
Program Management Reimbursables *(2)*	13		13
TOTAL FUND BALANCES	**$17,424**	**$3**	**$17,427**

(1) The restricted portion of the HI fund balance represents the remaining fund balance in the Payments to the Health Care Trust Funds appropriation, which is allocated to HI. There was no remaining fund balance in the SMI allocation of the Payments to the Health Care Trust Funds appropriation.

(2) These fund balances are reported in the Supplementary Financial Statement section under the "All Others" column of the Consolidating Balance Sheet.

NOTE 3: TRUST FUND INVESTMENTS, NET *(Dollars in Millions)*

Medicare Investments

FY 2002	Maturity Range	Interest Range	Value
HI			
Certificate	June 2003	4 3/8%	$3,385
Bonds	June 2003 to June 2017	5 1/4 - 9 1/4%	225,521
Accrued Interest			3,597
TOTAL HI INVESTMENTS			**$232,503**
SMI			
Certificate	June 2003	4 3/8%	$1,179
Bonds	June 2004 to June 2016	5 1/4 - 8 3/4%	37,626
Accrued Interest			625
TOTAL SMI INVESTMENTS			**$39,430**
TOTAL MEDICARE INVESTMENTS			**$271,933**

FY 2001	Maturity Range	Interest Range	Value
HI			
Certificates	June 2002	5 1/8 - 5 5/8%	$2,381
Bonds	June 2002 to June 2016	5 5/8 - 9 1/4%	194,756
Accrued Interest			3,272
TOTAL HI INVESTMENTS			**$200,409**
SMI			
Bonds	June 2002 to June 2016	5 5/8 - 8 3/4%	$41,978
Accrued Interest			705
TOTAL SMI INVESTMENTS			**$42,683**
TOTAL MEDICARE INVESTMENTS			**$243,092**

U.S. Treasury Special Issues are special public obligations for exclusive purchase by the Medicare trust funds. Special issues are always purchased and redeemed at face value. The face value less amounts retired to fund Medicare program expenses by the programs is the net amount outstanding reported in the Consolidating Balance Sheet. This schedule summarizes the nature and amount of investments in the Medicare trust funds.

NOTE 4: INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET *(Dollars in Millions)*

FY 2002

	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
Expenditure Transfer-in	$323	$690	$87	$3	$41	$1,144	$(1,144)	
Nonexpenditure Transfer-in	462	260				722	(722)	
Railroad Retirement Principal	412					412		$412
Military Service Contribution	123					123		123
Interest on OASDI FY 2001 Warrant	99					99		99
TOTAL INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET	**$1,419**	**$950**	**$87**	**$3**	**$41**	**$2,500**	**$(1,866)**	**$634**

FY 2001

	Medicare HI	Medicare SMI	Medicaid	Combined Total	Intra-CMS Eliminations	Consolidated Total
Income Tax on Benefits (OASDI)	$2,630			$2,630	$(2,630)	
Federal Matching Contributions		$1,592		1,592	(1,592)	
Medicaid Expansion SCHIP Reimbursement			$26	26	(26)	
Railroad Retirement Principal	431			431		$431
Military Service Contribution	123			123		123
TOTAL INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET	**$3,184**	**$1,592**	**$26**	**$4,802**	**$(4,248)**	**$554**

NOTE 5: ANTICIPATED CONGRESSIONAL APPROPRIATION

The CMS has recorded an $10,399 million anticipated Congressional appropriation to cover liabilities incurred as of September 30 by the Medicaid program, as discussed below:

Medicaid

Beginning in FY 1996, CMS has accrued an expense and liability for Medicaid claims incurred but not reported (IBNR) as of September 30. In FY 2002, the IBNR expense exceeded the available unexpended Medicaid appropriations in the amount of $10,399 million. A review of appropriation language by CMS's Office of General Counsel (OGC) has resulted in a determination that the Medicaid appropriation's indefinite authority provision allows for the entire IBNR amount to be reported as a funded liability. Consequently, CMS has recorded a $10,399 million anticipated appropriation in FY 2002 for IBNR claims that exceed the available appropriation.

NOTE 6: ACCOUNTS RECEIVABLE, NET *(Dollars in Millions)*

FY 2002	Medicare HI	Medicare SMI	Medicaid	All Others	Consolidated Total
Provider & Beneficiary Overpayment					
Accounts Receivable Principal	$3,472	$1,642		$621	$5,735
Less: Allowance for Uncollectible Accounts	(1,920)	(1,085)		(571)	(3,576)
Accounts Receivable, Net	1,552	557		50	2,159
Medicare Secondary Payer (MSP)					
Accounts Receivable Principal	34	13		2	49
Less: Allowance for Uncollectible Accounts	(6)	(1)			(7)
Accounts Receivable, Net	28	12		2	42
CMPs & Other Restitutions					
Accounts Receivable Principal	111	324		2	437
Less: Allowance for Uncollectible Accounts	(102)	(236)		(2)	(340)
Accounts Receivable, Net	9	88			97
Fraud and Abuse					
Accounts Receivable Principal	114	128			242
Less: Allowance for Uncollectible Accounts	(112)	(125)			(237)
Accounts Receivable, Net	2	3			5
Managed Care					
Accounts Receivable Principal	1	8		3	12
Less: Allowance for Uncollectible Accounts		(3)		(3)	(6)
Accounts Receivable, Net	1	5			6
Medicare Premiums					
Accounts Receivable Principal	151	337			488
Less: Allowance for Uncollectible Accounts	(40)	(37)			(77)
Accounts Receivable, Net	111	300			411
Audit Disallowances					
Accounts Receivable Principal		1	$1,430		1,431
Less: Allowance for Uncollectible Accounts			(539)		(539)
Accounts Receivable, Net		1	891		892
Other Accounts Receivable					
Accounts Receivable Principal			32	10	42
Less: Allowance for Uncollectible Accounts			(32)	(10)	(42)
Accounts Receivable, Net					
TOTAL ACCOUNTS RECEIVABLE PRINCIPAL	**$3,883**	**$2,453**	**$1,462**	**$638**	**$8,436**
Less: Allowance for Uncollectible Accounts	(2,180)	(1,487)	(571)	(586)	(4,824)
TOTAL ACCOUNTS RECEIVABLE, NET	**$1,703**	**$966**	**$891**	**$52**	**$3,612**

FY 2001	Medicare HI	Medicare SMI	Medicaid	All Others	Consolidated Total
Provider & Beneficiary Overpayment					
Accounts Receivable Principal	$4,724	$1,539		$556	$6,819
Less: Allowance for Uncollectible Accounts	(2,818)	(1,054)		(529)	(4,401)
Accounts Receivable, Net	1,906	485		27	2,418
Medicare Secondary Payer (MSP)					
Accounts Receivable Principal	117	87		8	212
Less: Allowance for Uncollectible Accounts	(49)	(43)		(3)	(95)
Accounts Receivable, Net	68	44		5	117
CMPs & Other Restitutions					
Accounts Receivable Principal	138	273		1	412
Less: Allowance for Uncollectible Accounts	(89)	(101)			(190)
Accounts Receivable, Net	49	172		1	222
Fraud and Abuse					
Accounts Receivable Principal	104	118			222
Less: Allowance for Uncollectible Accounts	(100)	(116)			(216)
Accounts Receivable, Net	4	2			6
Managed Care					
Accounts Receivable Principal	3	9		9	21
Less: Allowance for Uncollectible Accounts		(3)			(3)
Accounts Receivable, Net	3	6		9	18
Medicare Premiums					
Accounts Receivable Principal	125	276			401
Less: Allowance for Uncollectible Accounts	(29)	(24)			(53)
Accounts Receivable, Net	96	252			348
Audit Disallowances					
Accounts Receivable Principal	3	6	$1,146		1,155
Less: Allowance for Uncollectible Accounts	(1)	(1)	(197)		(199)
Accounts Receivable, Net	2	5	949		956
Other Accounts Receivable					
Accounts Receivable Principal			23	1	24
Less: Allowance for Uncollectible Accounts			(23)		(23)
Accounts Receivable, Net				1	1
TOTAL ACCOUNTS RECEIVABLE PRINCIPAL	**$5,214**	**$2,308**	**$1,169**	**$575**	**$9,266**
Less: Allowance for Uncollectible Accounts	(3,086)	(1,342)	(220)	(532)	(5,180)
TOTAL ACCOUNTS RECEIVABLE, NET	**$2,128**	**$966**	**$949**	**$43**	**$4,086**

Medicare accounts receivable are primarily composed of provider and beneficiary overpayments, and MSP overpayments. The MSP receivables are composed of paid claims in which Medicare should have been the secondary rather than the primary payer. Claims that have been identified to a primary payer are included in the MSP receivable amount. Accounts receivable data were primarily obtained from data provided by the Medicare contractors.

Currently Not Reportable/Currently Not Collectible Debt

In FY 1999, CMS implemented a number of policy changes in the reporting of delinquent accounts receivable. Provisions within the Office of Management and Budget (OMB) Circular A-129, ***Managing Federal Credit Programs***, allow an agency to move certain uncollectible delinquent debts into memorandum entries, which removes the receivable from the financial statements. The policy provides for certain debts to be written off closed without any further collection activity or reclassified as Currently Not Reportable. (This is also referred to as Currently Not Reportable/Collectible). This category of debt will continue to be referred for collection and litigation, but will not be reported on the financial statements because of the unlikelihood of collecting it. While these debts are not reported on the financial statements, the Currently Not Reportable/Collectible process permits and requires the use of collection tools of the Debt Collection Improvement Act of 1996. This allows delinquent debt to be worked until the end of its statutory collection life cycle.

In FY 2002, CMS continued the implementation of this policy and again performed analyses of its accounts receivable. CMS also continued to manage this debt by referring a significant portion of debt to Treasury for offset and cross-servicing in accordance with the Debt Collection Improvement Act of 1996.

Recognition of MSP Accounts Receivable

MSP accounts receivable are recorded on the financial statements as of the date the MSP recovery demand letter is issued. However, the MSP accounts receivable ending balance reflects an adjustment for expected reductions to group health plan accounts receivable for situations where CMS receives valid documented defenses to its recovery demands.

Write Offs and Adjustments

The implementation of the revised policies and other initiatives undertaken in recent fiscal years resulted in significant adjustments and write offs made to CMS's accounts receivable balance. CMS's financial reporting reflected additional adjustments, resulting from the validation and reconciliation efforts performed, revised policies and supplemental guidance provided by CMS to the Medicare contractors. The accounts receivable ending balance continues to reflect adjustments for accounts receivable which have been reclassified as Currently Not Reportable debt and unfiled cost reports.

The allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past five years. The Medicaid accounts receivable has been recorded at a net realizable value based on an historic analysis of actual recoveries and the rate of disallowances found in favor of the States. Such disallowances are not considered bad debts; the States elect to retain the funds until final resolution.

Non-entity Assets

Assets are either "entity" (the reporting entity holds and has authority to use the assets in its operations) or "non-entity" (the reporting agency holds but does not have authority to use in its operations). Before FY 2000 CMS reported its entity and non-entity assets in separate sections of the balance sheet. Since FY 2000 CMS has reported its entity and non-entity assets in a single combined section.

The only non-entity assets on CMS's Consolidating Balance Sheet are receivables for interest and penalties, net for the amount of $51 million ($42 million in FY 2001). The accrued interest associated with Provider and Beneficiary, MSP and Managed Care overpayments appear under All Others.

NOTE 7:
OTHER LIABILITIES *(Dollars in Millions)*

FY 2002	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Consolidated Total
Intragovernmental:						
Uncollected Revenue due Treasury	$68	$150			$51	$269
Other	9	15	$2		17	43
TOTAL OTHER INTRAGOVERNMENTAL LIABILITIES	**$77**	**$165**	**$2**		**$68**	**$312**
Deferred Revenue	$43	$150				$193
Suspense Account Deposit Funds					$11	11
Other	5	3				8
TOTAL OTHER LIABILITIES	**$48**	**$153**			**$11**	**$212**

FY 2001	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental:								
Uncollected Revenue due Treasury	$54	$117			$42	$213		$213
Unmatched SMI Premiums		1,592				1,592	$(1,592)	
Income Tax on Benefits	2,630					2,630	(2,630)	
FICA Tax Adjustment	200					200		200
SECA Tax Adjustment	253					253		253
Other	5	8	$1		18	32		32
TOTAL OTHER INTRAGOVERNMENTAL LIABILITIES	**$3,142**	**$1,717**	**$1**		**$60**	**$4,920**	**$(4,222)**	**$698**
Deferred Revenue	$48	$138				$186		$186
Suspense Account Deposit Funds					$14	14		14
Other	7	3				10		10
TOTAL OTHER LIABILITIES	**$55**	**$141**			**$14**	**$210**		**$210**

Potential Liability

The CMS routinely processes and settles cost reports and payment issues for institutional providers and healthcare insurers. As part of this process, some providers/insurers have filed suits challenging the amount of reimbursement to which they claim entitlement. The CMS cannot reasonably estimate the probability of the providers successfully winning their suits or the exact amount of the potential loss to the Medicare trust funds.

In the opinion of management, the resolution of these matters will not have a material impact on the results of operations and financial condition of CMS.

NOTE 8: ENTITLEMENT BENEFITS DUE AND PAYABLE *(Dollars in Millions)*

FY 2002	Medicare				Consolidated
	HI	SMI	Total	Medicaid	Total
Medicare Benefits Payable *(1)*	$14,074	$14,106	$28,180		$28,180
Demonstration Projects and HMO Benefits	32	24	56		56
Medicaid Benefits Payable *(2)*				$16,048	16,048
Medicaid Audit/Program Disallowances *(3)*				292	292
TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE	**$14,106**	**$14,130**	**$28,236**	**$16,340**	**$44,576**

FY 2001	Medicare				Consolidated
	HI	SMI	Total	Medicaid	Total
Medicare Benefits Payable	$13,617	$13,464	$27,081		$27,081
Medicaid Benefits Payable				$13,247	13,247
Medicaid Audit/Program Disallowances				113	113
TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE	**$13,617**	**$13,464**	**$27,081**	**$13,360**	**$40,441**

(1) Medicare benefits payable consists of a $28.2 billion estimate by CMS's Office of the Actuary of Medicare services incurred but not paid, as of September 30, 2002.

(2) Medicaid benefits payable of $16.0 billion is an estimate of the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2002.

(3) Medicaid audit and program disallowances of $292 million are contingent liabilities that have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to CMS. The CMS will be required to pay these amounts if the appeals are decided in the favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. The CMS defers the payment of these claims until the State provides additional supporting data. Based on historical data, CMS expects to eventually pay approximately 21.7 percent of total contingent liabilities. Therefore, of the total contingent liabilities of $1,342 million, CMS expects to pay approximately $292 million.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. As of September 30, 2001, there were 10,142 PRRB cases under appeal. A total of 2,138 new cases were filed in FY 2002. The PRRB rendered decisions on 50 cases in FY 2002 and 3,292 additional cases were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB gets no information on the value of these cases that are settled prior to a hearing. Since data is available for only the 50 cases that were decided in FY 2002, a reasonable liability estimate cannot be projected for the value of the 8,938 cases remaining on appeal as of September 30, 2002. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

NOTE 9:
LIABILITIES NOT COVERED BY BUDGETARY RESOURCES *(Dollars in Millions)*

FY 2002	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental:								
Accrued Payroll and Benefits	$1	$3			$1	$5		$5
TOTAL INTRAGOVERNMENTAL	**$1**	**$3**			**$1**	**$5**		**$5**
Entitlement Benefits Due and Payable			$10,999			$10,999		$10,999
Federal Employee and Veterans' Benefits	$3	$7				10		10
Accrued Payroll and Benefits	9	18	2			29		29
TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES	**$13**	**$28**	**$11,001**		**$1**	**$11,043**		**$11,043**
TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES	**$15,278**	**$15,517**	**$5,344**		**$79**	**$36,218**	**$(1,866)**	**$34,352**
TOTAL LIABILITIES	**$15,291**	**$15,545**	**$16,345**		**$80**	**$47,261**	**$(1,866)**	**$45,395**

FY 2001	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental:								
Accrued Payroll and Benefits	$1	$1				$2		$2
TOTAL INTRAGOVERNMENTAL	**$1**	**$1**				**$2**		**$2**
Entitlement Benefits Due and Payable			$7,779			$7,779		$7,779
Federal Employee and Veterans' Benefits	$3	$6	1			10		10
Accrued Payroll and Benefits	8	18	2			28		28
TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES	**$12**	**$25**	**$7,782**			**$7,819**		**$7,819**
TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES	**$16,825**	**$15,339**	**$5,583**	**$26**	**$74**	**$37,847**	**$(4,248)**	**$33,599**
TOTAL LIABILITIES	**$16,837**	**$15,364**	**$13,365**	**$26**	**$74**	**$45,666**	**$(4,248)**	**$41,418**

NOTE 10: MEDICARE BENEFIT PAYMENTS

Medicare Claims Estimated Improper Payments

Federal government audits require the review of programs for compliance with Federal laws and regulations. Accordingly, the OIG reviewed a statistically valid sample of Medicare claims to determine that claims were paid properly by Medicare contractors, and that services were actually performed and were medically necessary. Medicare, like other insurers, makes payments based on a standard claims form. The internal claims process involves reviewing claims as billed and paying the correct amount for the services rendered. The claims submitted for payment to Medicare contractors contained no visible errors. However, when the medical review asked for documentation from providers to support their claims, there was a 6.3 percent error rate with a dollar value in the range of $8.2-$18.4 billion ($13.3 billion midpoint). The majority of the errors fell into four broad categories: lack of medical necessity, insufficient or no documentation, incorrect coding, and noncovered/unallowable services.

Cost Report Settlement Process

The cost report settlement process represents the value of final outlays to providers based on fiscal intermediary (FI) audits, reviews and final settlements of Medicare cost reports. All institutional providers are required to file Medicare cost reports. For providers paid under the prospective payment system (PPS), the cost report includes costs that are not covered under PPS, such as disproportionate share hospital payments, indirect medical education payments, and other indirect costs. For providers paid on a cost basis, the cost report represents the total costs incurred by the provider for medical services to patients and reflects the final distribution of these costs to the Medicare program.

In FY 2002, 30,430 cost reports totaling $88.5 billion were reviewed. Approximately $72.4 billion represented inpatient claims to PPS providers. The cost report settlements, therefore, focused on the remaining non-PPS balance of about $16.1 billion. The significant decrease between FY 2001 and FY 2002 is due primarily to the implementation of PPS and the reversal of approximately $300 million of disallowances that were under appeal.

2002 Cost Report Summary

(Dollars in millions)

	Desk Reviews and Other	Audits	Total
Cost Reports	27,098	3,332	30,430
Costs Claimed	$35,469	$53,076	$88,545
Disallowed	$119	$(141)	$(22)

2001 Cost Report Summary

(Dollars in millions)

	Desk Reviews and Other	Audits	Total
Cost Reports	30,393	3,725	34,118
Costs Claimed	$36,810	$55,891	$92,701
Disallowed	$407	$350	$757

NOTE 11: TOTAL PROGRAM/ACTIVITY COSTS *(Dollars in Millions) (By Object Class)*

FY 2002	Medicare HI	Medicare SMI	Total Medicare	Medicaid	SCHIP	All Others	Consolidated Totals
PROGRAM COSTS							
Medicare							
Insurance Claims and Indemnities							
Fee for Service	$129,246	$91,367	$220,613				$220,613
Managed Care	17,847	15,942	33,789				33,789
Medicaid/SCHIP/TWI							
Grants and Subsidies				$149,371	$3,656	$8	153,035
TOTAL PROGRAM COSTS	**$147,093**	**$107,309**	**$254,402**	**$149,371**	**$3,656**	**$8**	**$407,437**
OPERATING COSTS							
Administrative							
Personal Services and Benefits	$141	$216	$357	$27	$1		$385
Contractual Services	761	1,177	1,938	140	5	$1	2,084
Grants and Subsidies	8	18	26	2			28
Travel and Transportation	3	6	9	1			10
Rental and Utilities	15	33	48	4			52
Printing and Reproduction	6	12	18	1			19
Supplies and Materials	1	2	3				3
Equipment	3	5	8	1			9
TOTAL ADMINISTRATIVE COSTS	**$938**	**$1,469**	**$2,407**	**$176**	**$6**	**$1**	**$2,590**
Depreciation and Amortization	$1	$2	$3				$3
Bad Debts and Writeoffs	(895)	134	(761)	$548			(213)
Medicare Integrity Program	968		968				968
Imputed Cost Subsidies	9	18	27	2			29
CLIA Program Costs						$78	78
Reimbursable Costs						2	2
Other Costs	14	30	44	4			48
TOTAL COSTS	**$148,128**	**$108,962**	**$257,090**	**$150,101**	**$3,662**	**$89**	**$410,942**
LESS: EARNED REVENUES							
Premiums Collected	$(1,524)	$(24,427)	$(25,951)				$(25,951)
Other Earned Revenues	(7)		(7)			$(60)	(67)
NET COST OF OPERATIONS	**$146,597**	**$84,535**	**$231,132**	**$150,101**	**$3,662**	**$29**	**$384,924**

FY 2001	Medicare HI	Medicare SMI	Medicare	Medicaid	SCHIP	All Others	Combined Totals	Intra-CMS Eliminations	Consolidated Total
PROGRAM COSTS									
Medicare									
Insurance Claims and Indemnities									
Fee for Service	$117,503	$80,285	$197,788				$197,788		$197,788
Managed Care	22,836	19,176	42,012				42,012		42,012
Medicaid/SCHIP/TWI									
Grants and Subsidies				$130,232	$3,725	$2	133,959	$(1,239)	132,720
TOTAL PROGRAM COSTS	**$140,339**	**$99,461**	**$239,800**	**$130,232**	**$3,725**	**$2**	**$373,759**	**$(1,239)**	**$372,520**
OPERATING COSTS									
Administrative									
Personal Services and Benefits	$141	$194	$335	$33			$368		$368
Contractual Services	756	980	1,736	156	$1		1,893		1,893
Grants and Subsidies	9	16	25	3			28		28
Travel and Transportation	3	6	9	1			10		10
Rental and Utilities	15	29	44	5			49		49
Printing and Reproduction	1	3	4				4		4
Supplies and Materials	1	2	3				3		3
Equipment	5	8	13	2			15		15
TOTAL ADMINISTRATIVE COSTS	**$931**	**$1,238**	**$2,169**	**$200**	**$1**		**$2,370**		**$2,370**
Depreciation and Amortization	$2	$3	$5	$1			$6		$6
Bad Debts and Writeoffs	76	88	164	10			174		174
Medicare Integrity Program	905		905				905		905
Imputed Cost Subsidies	8	16	24	3			27		27
CLIA Program Costs						$143	143		143
Reimbursable Costs						4	4		4
Other Costs	14	26	40	4			44		44
TOTAL COSTS	**$142,275**	**$100,832**	**$243,107**	**$130,450**	**$3,726**	**$149**	**$377,432**	**$(1,239)**	**$376,193**
LESS: EARNED REVENUES									
Premiums Collected	$(1,439)	$(22,307)	$(23,746)				$(23,746)		$(23,746)
Other Earned Revenues	(4)		(4)	$(1,239)		$(62)	(1,305)	$1,239	(66)
NET COST OF OPERATIONS	**$140,832**	**$78,525**	**$219,357**	**$129,211**	**$3,726**	**$87**	**$352,381**		**$352,381**

For purposes of financial statement presentation, non-CMS administrative costs are considered expenses to the Medicare trust funds when outlayed by Treasury even though some funds may have been used to pay for assets such as property and equipment. In this regard, the SSA reported $70.7 million of Property and Equipment, Net attributable to the Medicare program as of September 30, 2002. This amount is not included in CMS's Consolidating Balance Sheet as assets related to the Medicare program. However, funds withdrawn from the trust funds by SSA during FY 2002 to pay for this activity are reported as Transfers-out in the Statement of Changes in Net Position. The SSA administrative costs are reported to CMS by Treasury. These expenses are also reported by SSA on their FY 2002 Annual Financial Statement. The CMS administrative costs have been allocated to the Medicare, Medicaid, SCHIP and TWI programs based on the CMS cost allocation system. Administrative costs allocated to the Medicare program include $1.1 billion paid to Medicare contractors to carry out their responsibilities as CMS's agents in the administration of the Medicare program.

The chart below details the Administrative Expenses by agency. The CMS is only one of several agencies that charge some administrative expenses to Medicare.

Administrative Expenses

(Dollars in millions)

FY 2002	Medicare					All	Consolidated
	HI	SMI	Total	Medicaid	SCHIP	Others	Total
Administrative Expenses by Agency							
Treasury	$40		$40				$40
CMS	654	$1,398	2,052	$176	$6	$1	2,235
Peer Review Organizations	244	71	315				315
TOTAL ADMINISTRATIVE EXPENSES	**$938**	**$1,469**	**$2,407**	**$176**	**$6**	**$1**	**$2,590**

Administrative Expenses

(Dollars in millions)

FY 2001	Medicare					Consolidated
	HI	SMI	Total	Medicaid	SCHIP	Total
Administrative Expenses by Agency						
Treasury	$40		$40			$40
CMS	617	$1,183	1,800	$200	$1	2,001
Peer Review Organizations	274	55	329			329
TOTAL ADMINISTRATIVE EXPENSES	**$931**	**$1,238**	**$2,169**	**$200**	**$1**	**$2,370**

NOTE 12: PRIOR PERIOD ADJUSTMENTS *(Dollars in Millions)*

FY 2002	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Consolidated Total
Cumulative Results of Operations						
Change in Accounting Principle	$(212)	$9	$53	$2	$38	$(110)
TOTAL PRIOR PERIOD ADJUSTMENTS	**$(212)**	**$9**	**$53**	**$2**	**$38**	**$(110)**

	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Consolidated Total
Unexpended Appropriations						
Change in Accounting Principle			$110			$110
TOTAL PRIOR PERIOD ADJUSTMENTS			**$110**			**$110**

In FY 2002 CMS adopted accrual-based accounting for the transfer of trust funds between CMS and the Bureau of Public Debt. (Previously, CMS had employed cash-based accounting, recognizing and recording trust fund transfers only when cash was either disbursed or received). Under accrual accounting, CMS has recognized as a prior period adjustment a transfer of $110 million from the SMI trust fund to Medicaid that occurred in FY 2002 (in the Unexpended Appropriation section above). The amounts reported in the Cumulative Results of Operations section reflect the allocation among CMS programs of a prior period adjustment recorded in the Program Management appropriation.

NOTE 13: BUDGETARY FINANCING SOURCES: OTHER ADJUSTMENTS *(Dollars in Millions)*

FY 2002	Medicare HI	Medicare SMI	Medicaid	SCHIP	Consolidated Total
Unexpended Appropriations					
Reversal of Accrual of FY 2001 Income Tax on OASDI	$(2,630)				$(2,630)
Reversal of Accrual of FY 2001 Federal Matching Contributions		$(1,592)			(1,592)
Net Increase in Anticipated Congressional Appropriation			$3,455		3,455
Withdrawal of Appropriation	(2)		(760)		(762)
Redistribution of SCHIP FY 1999 Appropriation				$(2,819)	(2,819)
TOTAL OTHER ADJUSTMENTS	**$(2,632)**	**$(1,592)**	**$2,695**	**$(2,819)**	**$(4,348)**

NOTE 14: TAXES AND OTHER NON-EXCHANGE REVENUE *(Dollars in Millions)*

FY 2002	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Consolidated Total
FICA Tax Receipts	$141,990					$141,990
SECA Tax Receipts	10,038					10,038
Trust Fund Investment Interest	14,194	$2,837				17,031
Criminal Fines	430					430
Civil Monetary Penalties and Damages	326					326
Administrative Fees	10					10
Other Income	1	2				3
TAXES AND OTHER NON-EXCHANGE REVENUE	**$166,989**	**$2,839**				**$169,828**

For periods after December 31, 1993, employees and employers are each required to contribute 1.45 percent of employees' wages, and self-employed persons are required to contribute 2.90 percent of net income, with no limitation, to the HI trust fund. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages.

NOTE 15:
OTHER TRANSFERS-IN/OUT *(Dollars in Millions)*

FY 2002

Transfers-in Without Reimbursement	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
Medicare Benefit Transfers	$145,722	$107,322				$253,044	$(253,044)	
Transfers to HCFAC	1,235					1,235	(1,235)	
Federal Matching Contributions		76,726				76,726	(76,726)	
Allocation to CMS Programs	692	1,481	$188	$6	$19	2,386	(2,386)	
Fraud and Abuse Appropriation	101					101	(101)	
Transfer-Uninsured Coverage	442					442	(442)	
Prog. Mngmt. Admin. Expense *(1)*	202					202	(202)	
Military Service Contribution	41	40				81		$81
Income Tax OASDI Benefits *(2)*	8,316					8,316	(8,316)	
Railroad Retirement Principal	373					373		373
Medicaid Part B Premiums			2			2	(2)	
Gifts and Miscellaneous	1	1				2		2
TOTAL TRANSFERS-IN	**$157,125**	**$185,570**	**$190**	**$6**	**$19**	**$342,910**	**$(342,454)**	**$456**

FY 2002

Transfers-out Without Reimbursement	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
SSA Administrative Expenses	$(706)	$(700)				$(1,406)		$(1,406)
Medicare Benefit Transfers	(145,722)	(107,322)				(253,044)	$253,044	
Transfers to HCFAC	(1,235)					(1,235)	1,235	
Federal Matching Contributions		(76,726)				(76,726)	76,726	
Transfers to Program Management	(890)	(1,496)				(2,386)	2,386	
Fraud and Abuse Appropriation	(101)					(101)	101	
Transfer-Uninsured Coverage	(442)					(442)	442	
Prog. Mngmt. Admin. Expense *(1)*	(202)					(202)	202	
Income Tax OASDI Benefits *(2)*	(8,316)					(8,316)	8,316	
Medicaid Part B Premiums		(2)				(2)	2	
Office of the Secretary	(8)	(5)				(13)		(13)
Payment Assessment Commission	(5)	(3)				(8)		(8)
Railroad Retirement Board		(5)				(5)		(5)
TOTAL TRANSFERS-OUT	**$(157,627)**	**$(186,259)**				**$(343,886)**	**$342,454**	**$(1,432)**
TOTAL TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT	**$(502)**	**$(689)**	**$190**	**$6**	**$19**	**$(976)**		**$(976)**

(1) During FY 2002, the Payments to the Health Care Trust Funds appropriation paid the HI trust fund $202 million to cover the Medicaid, SCHIP and TWI programs' share of CMS's administrative costs.

(2) The Omnibus Budget Reconciliation Act of 1993 increased the maximum percentage of Old Age Survivors and Disability Insurance (OASDI) benefits that are subject to Federal income taxation under certain circumstances from 50 percent to 85 percent. The revenues, resulting from this increase, are transferred to the HI trust fund.

Funds are obtained from the HI and SMI trust funds as cash is needed to pay for Program Management appropriation expenses. During FY 2002, a total of $1,953 million was obtained from the trust funds to cover cash outlays. Of this amount, $1,674 million was needed to pay for expenses incurred against current year obligations and $279 million (of which $16 million was transferred to the CLIA program) was needed for expenses incurred against prior year obligations.

Federal Matching Contributions

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. The monthly SMI premium per beneficiary was $50.00 from October 2001 through December 2001 and $54.00 from January 2002 through September 2002. Premiums collected from beneficiaries totaled $24.4 billion and were matched by a $76.7 billion contribution from the Federal government.

NOTE 16:

GROSS COST AND EXCHANGE REVENUE BY BUDGET FUNCTIONAL CLASSIFICATION *(Dollars in Millions)*

FY 2002	Medicare	Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental Costs	$254	$25	$279		$279
With the Public	256,836	153,827	410,663		410,663
Gross Cost	257,090	153,852	410,942		410,942
Less: Exchange Revenue	(25,958)	(60)	(26,018)		(26,018)
NET COST	**$231,132**	**$153,792**	**$384,924**		**$384,924**

FY 2001	Medicare	Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental Costs	$306	$1,280	$1,586	$(1,239)	$347
With the Public	242,801	133,045	375,846		375,846
Gross Cost	243,107	134,325	377,432		376,193
Less: Exchange Revenue	(23,750)	(1,301)	(25,051)	1,239	(23,812)
NET COST	**$219,357**	**$133,024**	**$352,381**		**$352,381**

NOTE 17:
STATEMENT OF BUDGETARY RESOURCES DISCLOSURES *(Dollars in Millions)*

The amounts of direct and reimbursable obligations incurred against amounts apportioned under Category A, Category B and Exempt from Apportionment are shown below:

FY 2002	Combined Totals
Category A	
Direct	$19,474
Reimbursable	95
TOTAL CATEGORY A	**$19,569**

FY 2002	Combined Totals
Category B	
Direct	$483,266
Reimbursable	2
TOTAL CATEGORY B	**$483,268**

FY 2002	Combined Totals
Exempt	$3,862
TOTAL OBLIGATIONS INCURRED	**$506,699**

FY 2002 Legal Arrangements Affecting Use of Unobligated Balances

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Statement of Budgetary Resources. The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is reported as Temporarily Not Available Pursuant to Public Law in the Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and currently become available for obligation as needed. The entire trust fund balances in the amount of $265,620 million as of September 30, 2002 are included in Investments on the Balance Sheet. The following table presents trust fund activities and balances for FY 2002:

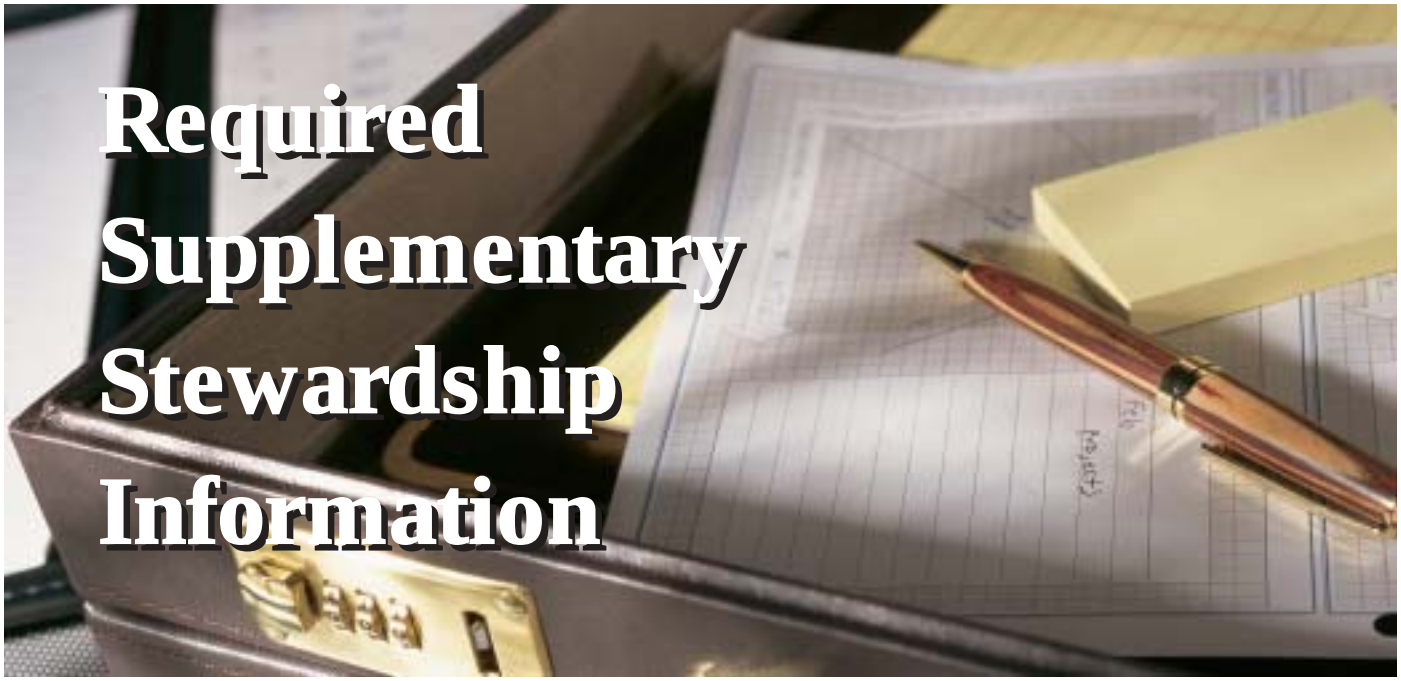
	(in Millions)
TRUST FUND BALANCE, BEGINNING	**$237,589**
Receipts	285,416
Less Obligations	256,392
Less Transfers	993
Excess of Receipts Over Obligations	28,031
TRUST FUND BALANCE, END	**$265,620**

NOTE 18: REIMBURSEMENT OF TITLE XXI EXPENSES

An amendment to the State Children's Health Insurance Program (SCHIP) was passed on December 21, 2000 that allows for Medicaid expansion of the SCHIP services paid by title XIX (Medicaid) to be reimbursed from amounts appropriated under title XXI (SCHIP) for expenditures incurred for FYs 1998 through 2000. This reimbursement was accomplished in FY 2001. The total Medicaid Expansion SCHIP expenditures incurred in FYs 1998 through 2000 was approximately $1.238 billion; of this amount, $1.212 billion was reimbursed and the remaining $26 million was recorded as a receivable in FY 2001 and collected in FY 2002.

NOTE 19: CANCELED APPROPRIATIONS

In accordance with section 801 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) enacted on December 21, 2000, redistributed SCHIP allotments for FYs 1998 and 1999 were to remain available to the States through September 30, 2002 and any unused amounts are to be returned to Treasury. These amounts will be returned to Treasury in accordance to the requirements of canceling appropriations.



Required Supplementary Stewardship Information

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for almost four decades. A brief description of the provisions of Medicare's Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds is included on pages 3–4 of this financial report.

The required supplementary stewardship information (RSSI) contained in this section is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are a description of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSSI material is generally drawn from the ***2002 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds***[1], which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

Printed copies of the Trustees Report may be obtained from CMS's Office of the Actuary (410-786-6386). The report is also available online at **www.hcfa.gov/pubforms/tr/**.

Please note that the 2002 Trustees Report for Medicare (issued March 26, 2002) was used as the source document for this FY 2002 CFO Financial Report. We anticipate that the Government-wide financial statement report for FY 2002 (expected to be issued March 31, 2003) will contain updated information from the 2003 Trustees Report (which is expected to be issued on or near March 15, 2003). Thus, some data related to the Medicare trust funds contained in this FY 2002 CFO Financial Report may differ from that contained in the FY 2002 ***Financial Report of the United States Government.***

[1] In past years, separate annual reports were issued for the HI and SMI trust funds. Beginning in 2002, the reports have been combined to more effectively convey the financial outlook for the Medicare program as a whole.

ACTUARIAL PROJECTIONS

Cashflow in Nominal Dollars

Using nominal dollars[2] for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances. Over longer periods, however, the changing value of the dollar can complicate efforts to compare dollar amounts in different periods and can create severe barriers to interpretation, since projections must be linked to something that the mind can comprehend in today's experience.

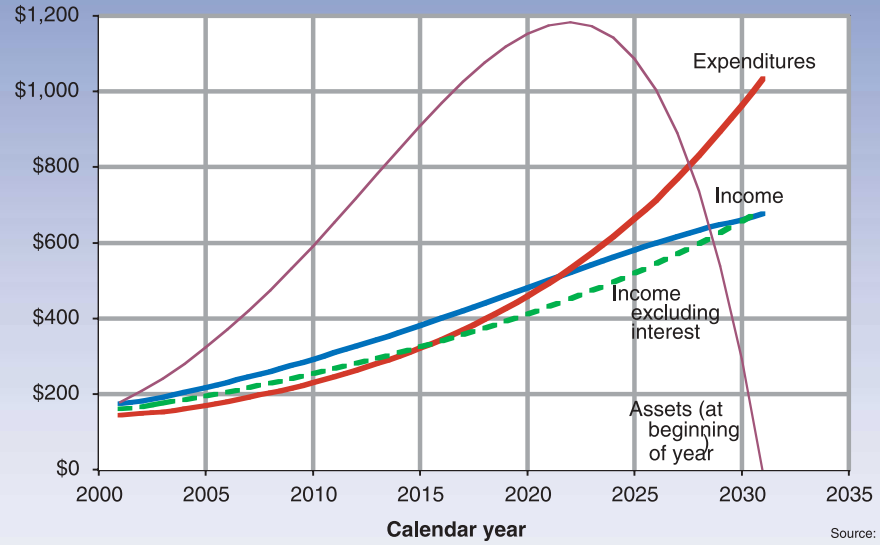
For this reason, long-range (75-year) Medicare projections in nominal dollars are seldom used and are not presented here. Instead, nominal-dollar estimates for the HI trust fund are displayed only through the projected date of depletion, currently the year 2030. Estimates for SMI are presented only for the next 10 years, primarily due to the fact that under present law, the SMI trust fund is automatically in financial balance every year.

HI

Chart 1 shows the actuarial estimates of HI income, expenditures, and assets for each of the next 30 years, in nominal dollars. Income includes payroll taxes, income from the taxation of Social Security benefits, interest earned on the U.S. Treasury securities held by the trust fund, and other miscellaneous revenue. Expenditures include benefit payments and administrative expenses. The estimates are for the "open group" population—all persons who will participate during the period as either taxpayers or beneficiaries, or both—and consist of payments from, and on behalf of, employees now in the workforce, as well as those who will enter the workforce over the next 30 years. The estimates also include expenditures attributable to these current and future workers, in addition to current beneficiaries.

Chart 1—HI Income, Expenditures, and Assets 2001-2031

(In billions)



Source: CMS/OACT

[2] Dollar amounts that are not adjusted for inflation or other factors are referred to as "nominal."

As chart 1 shows, under the intermediate assumptions HI expenditures would begin to exceed income including interest in 2022 and income excluding interest in 2016. This situation is due in part to the attainment of Medicare eligibility, starting in 2011, of those born during the 1946-1964 baby boom. It also arises as a result of health cost increases that are expected to continue to grow faster than workers' earnings. Beginning in 2022, the trust fund would start redeeming trust fund assets; in 2030, the assets would be depleted.

The projected year of depletion of the trust fund is very sensitive to assumed future economic and other trends. Under less favorable conditions the cash flow could turn negative much earlier and thereby accelerate asset exhaustion.

By law, Medicare trust fund assets are invested in special U.S. Treasury Securities, which earn interest while Treasury uses those cash resources for other Federal purposes. During times of Federal "on-budget" surpluses, this process reduces the Federal debt held by the public. In times of Federal budget deficits, Medicare surpluses reduce the amount that must be borrowed from the public to finance those deficits. The trust fund assets are claims on the Treasury that, when redeemed, will have to be financed by raising taxes, borrowing from the public, or reducing other Federal expenditures. (When the assets are financed by borrowing, the effect is to defer today's costs to later generations who will ultimately repay the funds being borrowed for today's Medicare beneficiaries.) The existence of large trust fund balances, therefore, represents an important obligation of the Government to pay future Medicare benefits but does not necessarily make it easier for the Government to pay those benefits.

SMI

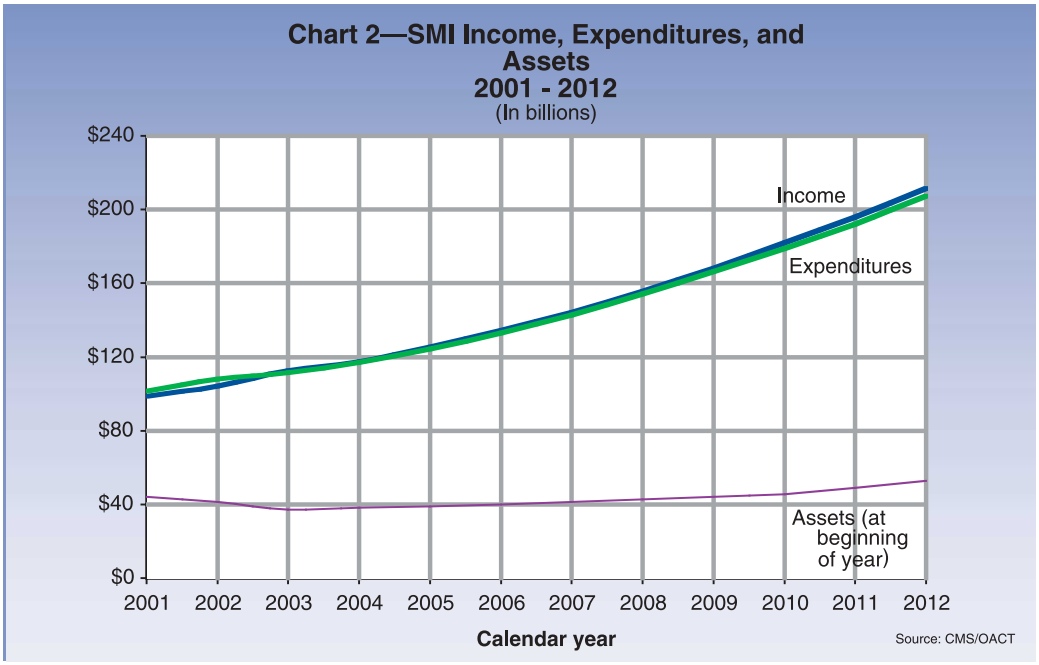
Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets for each of the next 10 years, in nominal dollars. Whereas HI estimates are displayed through the year 2030, SMI estimates cover only the next 10 years, as SMI differs fundamentally from HI in regard to the way it is financed. In particular, SMI financing is not at all based on payroll taxes but instead on monthly premiums and income from the general fund of the U.S. Treasury—both of which are established annually to cover the following year's expenditures. Estimates of SMI income and expenditures, therefore, are virtually the same, as illustrated in chart 2, and so are not shown in nominal dollars separately beyond 10 years.

Income includes monthly premiums paid by, or on behalf of, beneficiaries, transfers from the general fund of the U.S. Treasury, and interest earned on the U.S. Treasury securities held by the trust fund.[3] Chart 2 displays only total income; it does not represent income excluding interest. The difference between the two is not visible graphically since interest is not a significant source of income.[4] Expenditures include benefit payments as well as administrative expenses.

[3] In the financial statements for CMS, Medicare income and expenditures are shown from a "trust fund perspective." All sources of income to the trust funds are reflected, and the actuarial projections can be used to assess the financial status of each trust fund. Corresponding estimates for Medicare and other Federal social insurance programs are also shown in the annual Financial Report of the United States Government, also known as the consolidated financial statements. On a consolidated basis, the estimates are shown from a "Federal budget" perspective. In particular, certain categories of trust fund income—primarily interest payments and SMI general revenues—are excluded because they represent intragovernmental transfers, rather than revenues received from the public. Thus, the consolidated financial statements focus not on the financial status of individual trust funds, but on the overall balance between revenues and outlays for the Federal budget. Each perspective is appropriate and useful for its intended purpose.

[4] Interest income is generally about 4 percent of total SMI income.

As chart 2 indicates, SMI income is very close to expenditures. As noted earlier, this is due to SMI's financing mechanism. Under present law, SMI is automatically in financial balance every year, regardless of future economic and other conditions.

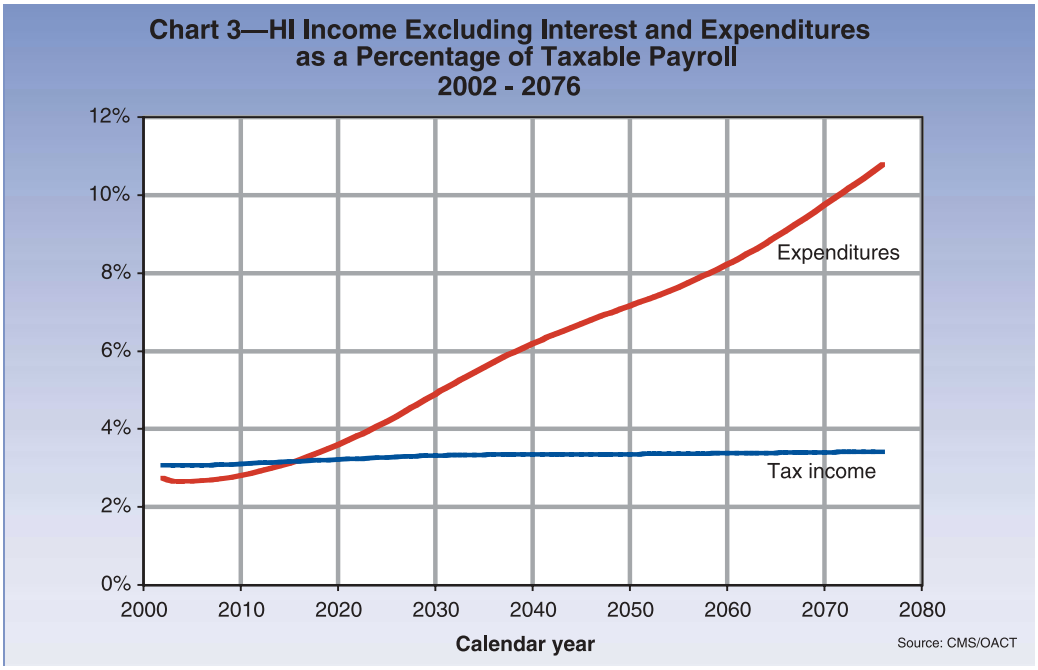


HI Cashflow as a Percent of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. Because of the difficulty in comparing dollar values for different periods without some type of relative scale, income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as "taxable payroll").

Chart 3 illustrates income excluding interest and expenditures as a percentage of taxable payroll over the next 75 years. As it was in the 2001 report, the per beneficiary long-range growth in the 2002 report is assumed to be the level of per capita gross domestic product (GDP) growth plus 1 percentage point—reflecting an expectation that the impact of advances in medical technology on health care costs will continue, both in Medicare and in the health sector as a whole.

Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll will remain constant at 2.90 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries become subject to such taxation over time. Thus, as chart 3 shows, the income rate is not expected to increase significantly over current levels. On the other hand, expenditures as a percentage of taxable payroll sharply escalate—in part due to health care cost increases that exceed wage growth, but also due to the attainment of Medicare eligibility of those born during the 1946-1964 baby boom.



HI and SMI Cashflow as a Percent of GDP

Expressing Medicare incurred expenditures as a percentage of the GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

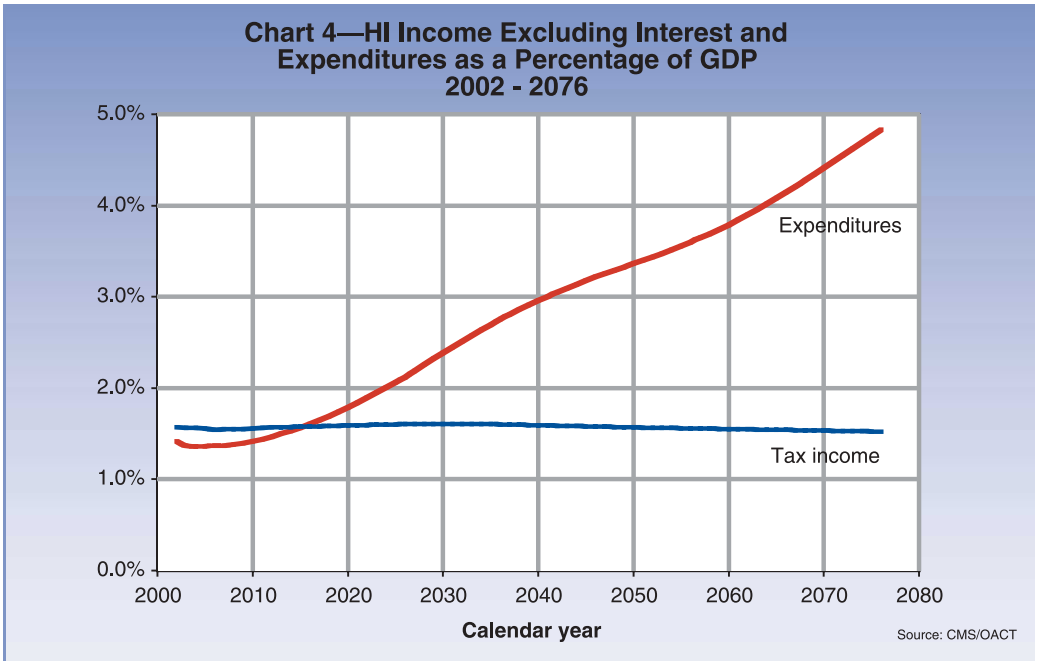
HI

Chart 4 shows HI income excluding interest and expenditures over the next 75 years expressed as a percentage of GDP. In 2001, the expenditures were $143.4 billion, which was 1.4 percent of GDP. Following slight reductions in 2003 and 2004, this percentage is projected to increase steadily throughout the remainder of the 75-year period.

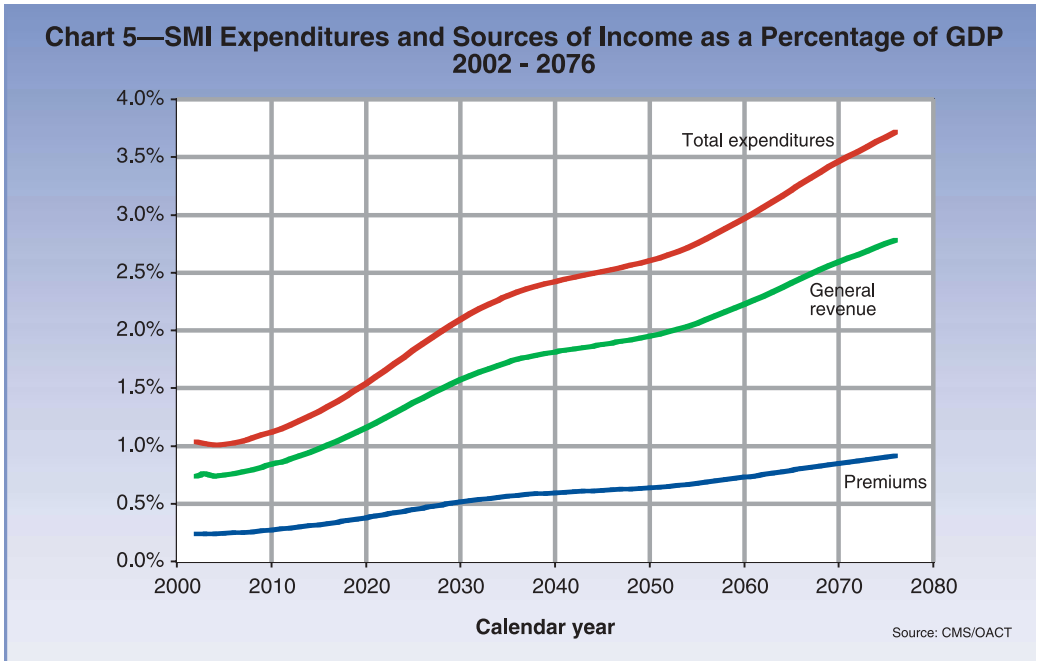
SMI

As noted earlier, because of the SMI financing mechanism in which income mirrors expenditures, it is not necessary to test for imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and Federal general revenue payments.

Chart 5 shows SMI expenditures over the next 75 years expressed as a percentage of GDP. In 2001, SMI expenditures were $101.4 billion, which was 1.0 percent of GDP. After 2005, this percentage is projected to increase steadily, reflecting growth in the volume and intensity of services provided per beneficiary throughout the projection period, together with the effects of the baby boom eligibility for retirement.



In the SMI expenditure projections, as in those for HI, the per beneficiary long-range growth rate is assumed to equal per capita GDP growth plus 1 percentage point. The growth rates are estimated year by year for the next 12 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 13 to 25 is assumed to grade smoothly into the long-range assumptions.

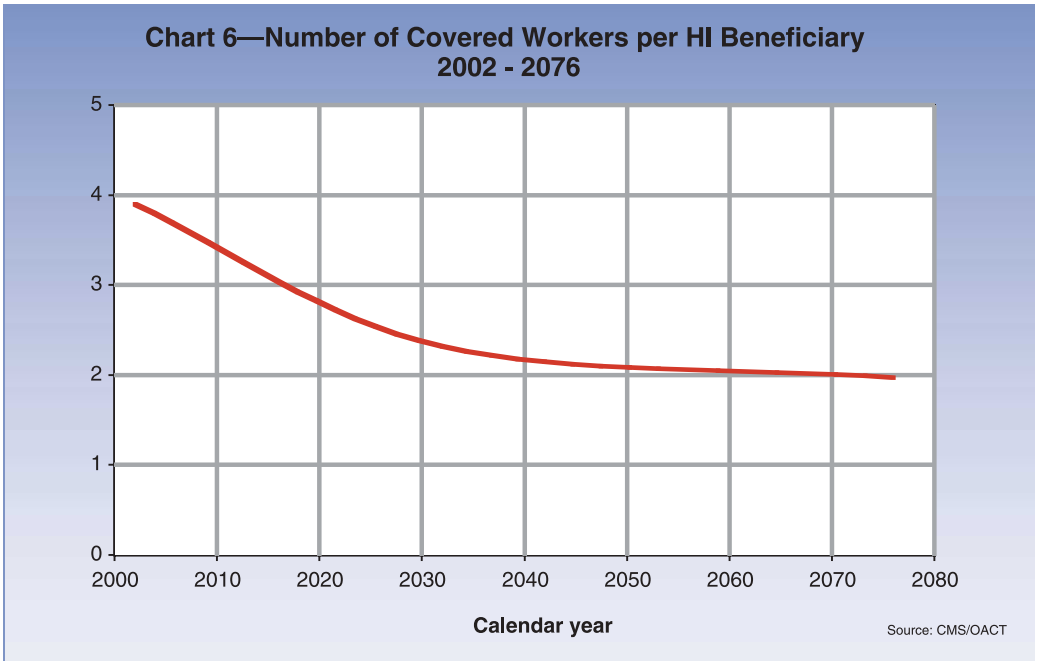


Also shown in chart 5 are SMI general revenue transfers and premium income expressed as a percentage of GDP.[5] Under present law, premiums will cover roughly 25 percent of total expenditures. As indicated, both sources of revenue would increase more rapidly than the GDP over time, to match the faster growth rates for SMI expenditures.

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 6 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 2001, every beneficiary had almost 4.0 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary in 2076.



ACTUARIAL PRESENT VALUES

Projected future expenditures can be summarized by computing an "actuarial present value." This value represents the lump-sum amount that, if invested today in trust fund

[5] See footnote 3 regarding the treatment of SMI general revenue income in the consolidated financial statement of the U.S. government.

securities, would be just sufficient to pay each year's expenditures over the next 75 years, with the fund being drawn down to zero at the end of the period. Similarly, future revenues (excluding interest) can be summarized as a single, equivalent amount as of the current year.

Actuarial present values are calculated by discounting the future annual amounts of non-interest income and expenditures at the assumed rates of interest credited to the HI and SMI trust funds. Present values are computed as of the beginning of the 75-year projection period for three different groups of participants: current workers and other individuals who have not yet attained eligibility age; current beneficiaries who have attained eligibility age; and new entrants, or those who are expected to become participants in the future.

Table 1 sets forth, for each of these three groups, the actuarial present values of all future HI and SMI expenditures and all future non-interest income for the next 75 years. Also shown is the net present value of cashflow, which is calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income.

TABLE 1
Actuarial Present Values of Hospital Insurance and Supplementary Medical Insurance Revenues and Expenditures: 75-year Projection as of January 1, 2002

(In billions)

	HI			SMI[2]		
Actuarial present value[1] of estimated future income (excluding interest) received from or on behalf of:	**2002**	**2001**	**2000**	**2002**	**2001**	**2000**
Current participants[3] who, at the start of projection period:						
Have not yet attained eligibility age (ages 15-64)	$4,408	$4,136	$3,757	$7,423	$7,378	$6,109
Have attained eligibility age (age 65 and over)	125	113	97	1,008	1,032	934
Those expected to become participants (under age 15)	3,753	3,507	3,179	2,402	2,370	1,616
All current and future participants	**$8,286**	**$7,757**	**$7,033**	**$10,833**	**$10,780**	**$8,659**
Actuarial present value[1] of estimated future expenditures[4] paid to or on behalf of:						
Current participants[3] who, at the start of projection period:						
Have not yet attained eligibility age (ages 15-64)	$9,195	$8,568	$6,702	$7,463	$7,415	$6,094
Have attained eligibility age (age 65 and over)	1,747	1,693	1,681	1,132	1,159	1,051
Those expected to become participants (under age 15)	2,470	2,225	1,349	2,238	2,206	1,514
All current and future participants	**$13,412**	**$12,487**	**$9,732**	**$10,833**	**$10,780**	**$8,659**
Actuarial present value[1] of estimated future income (excluding interest) less expenditures	-5,126	-4,730	-2,700	0	0	0
Trust fund assets at start of period	209	177	141	41	44	45
Assets at start of period plus actuarial present value[1] of estimated future income (excluding interest) less expenditures	**-$4,917**	**$-4,553**	**$-2,558**	**$41**	**$44**	**$45**

[1] Present values are computed on the basis of the intermediate set of economic and demographic assumptions specified in the Report of the Boards of Trustees for the year shown and over the 75-year projection period beginning January 1 of that year.

[2] SMI income includes premiums paid by beneficiaries and general revenue contributions made on behalf of beneficiaries. See footnote 3 on page 67 concerning treatment of SMI general revenues in the consolidated financial statement of the U.S. government.

[3] Current participants are the "closed group" of individuals age 15 and over at the start of the period. The projection period for these current participants would theoretically cover all of their working and retirement years, a period that could be greater than 75 years in some instances. As a practical matter, the present values of future income and expenditures from/for current participants beyond 75 years are not material. The projection period for new entrants covers the next 75 years.

[4] Expenditures include benefit payments and administrative expenses.

Note: Totals do not necessarily equal the sums of rounded components.

As shown in table 1, the HI trust fund has an actuarial deficit of more than $4.9 trillion over the 75-year projection period, as compared to more than $4.5 trillion in the 2001 financial report. SMI, on the other hand, does not have similar problems because it is automatically in financial balance every year due to its financing mechanism.[6]

The existence of a large actuarial deficit for the HI trust fund indicates that, under reasonable assumptions as to economic, demographic, and health cost trends for the future, HI income is expected to fall substantially short of expenditures in the long range. Although the deficits are not anticipated in the immediate future, as indicated by the preceding cashflow projections, they nonetheless pose a serious financial problem for the HI trust fund.

It is important to note that no liability has been recognized on the balance sheet for future payments to be made to current and future program participants beyond the existing "incurred but not reported" Medicare claim amounts as of September 30, 2002. This is because Medicare is accounted for as a social insurance program rather than a pension program. Accounting for a social insurance program recognizes the expense of benefits when they are actually paid, or are due to be paid, because benefit payments are primarily nonexchange transactions and, unlike employer-sponsored pension benefits for employees, are not considered deferred compensation. Accrual accounting for a pension program, by contrast, recognizes retirement benefit expenses as they are earned so that the full actuarial present value of the worker's expected retirement benefits has been recognized by the time the worker retires.

ACTUARIAL ASSUMPTIONS AND SENSITIVITY ANALYSIS

In order to make projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that the trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions, including changes in wages and the consumer price index (CPI), fertility rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period.

[6] As noted in footnote 3 on page 67, the actuarial deficit is calculated from a *trust fund perspective*, reflecting all sources of income and expenditures to or from the HI and SMI trust funds. If, instead, a *budget perspective* is considered, as used in the consolidated financial statement, one would compare Medicare outlays to the public with revenues received directly from the public. On this basis, transfers to the SMI trust fund from the general fund of the Treasury would be excluded, with the result that the present value of projected SMI expenditures through 2076 would exceed the present value of projected SMI premium revenue alone by $8.1 trillion. When added to the corresponding differential for HI, the present value of expenditures for the Medicare program overall is projected to exceed receipts from the public by $13.3 trillion. This *budget impact* reflects both (i) the cost to the Federal budget of SMI general revenues provided under current law and (ii) the amount that HI revenues would have to be increased to enable HI benefits to be paid at their currently scheduled level—for which there is no provision in current law.

REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Table 2 shows some of the underlying assumptions used in the projections of Medicare spending displayed in this section. Further details on these assumptions are available in the OASDI and Medicare Trustees Reports for 2002. In practice, a number of specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the utilization, volume, and intensity of each type of service. The per beneficiary cost increases displayed in table 2 reflect the overall impact of these more detailed assumptions.

TABLE 2
Medicare Assumptions

					Annual percentage change in:				
	Fertility rate[1]	Net immigration	Real wage differential[2]	Wages	CPI	Real GDP	Per beneficiary cost[3] HI	Per beneficiary cost[3] SMI	Real Interest rate[4]
2002	2.13	900,000	1.8	3.1	1.3	0.7	3.5	4.2	3.6
2005	2.10	900,000	1.2	4.1	2.9	3.2	4.5	5.2	3.5
2010	2.07	900,000	1.0	4.1	3.0	2.2	4.4	5.5	3.0
2020	1.99	900,000	1.1	4.1	3.0	1.8	4.4	5.2	3.0
2030	1.95	900,000	1.1	4.1	3.0	1.8	5.9	5.6	3.0
2040	1.95	900,000	1.1	4.1	3.0	1.8	6.1	5.3	3.0
2050	1.95	900,000	1.1	4.1	3.0	1.7	5.2	4.9	3.0
2060	1.95	900,000	1.1	4.1	3.0	1.7	5.3	5.4	3.0
2070	1.95	900,000	1.1	4.1	3.0	1.7	5.5	5.2	3.0
2076	1.95	900,000	1.1	4.1	3.0	1.6	5.4	5.1	3.0

[1] Average number of children per woman.
[2] Difference between percentage increases in wages and the CPI.
[3] See text for nature of this assumption.
[4] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

Estimates made in prior years have sometimes changed substantially because of revisions to the assumptions, which are due either to changed conditions or to more recent experience. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty. In order to illustrate the magnitude of the sensitivity of the long-range projections, six of the key assumptions were varied individually to determine the impact on the HI actuarial present values and net cashflows.[7] The assumptions varied are the fertility rate, net immigration, real-wage differential, CPI, real-interest rate, and health care cost factors.[8]

[7] Sensitivity analysis is not done for the SMI program due to its financing mechanism. Any change in assumptions would have no impact on the net cashflow, since the change would affect income and expenditures equally.

[8] The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity. CMS is sponsoring a current research effort by the Rand Corporation that is expected to provide the information necessary to produce such estimates.

For this analysis, the intermediate economic and demographic assumptions in the ***2002 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*** are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2002 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 7 through 12 show the net annual HI cashflow in nominal dollars and the present value of this net cashflow for each assumption varied. In most instances, the charts depicting the estimated net cashflow indicate that, after increasing in the early years, net cashflow decreases steadily through 2030 under all three scenarios displayed. On the present value charts, the same pattern is evident, though the magnitudes are lower because of the discounting process used for computing present values.

Fertility Rate

Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 1.95, and 2.2 children per woman.

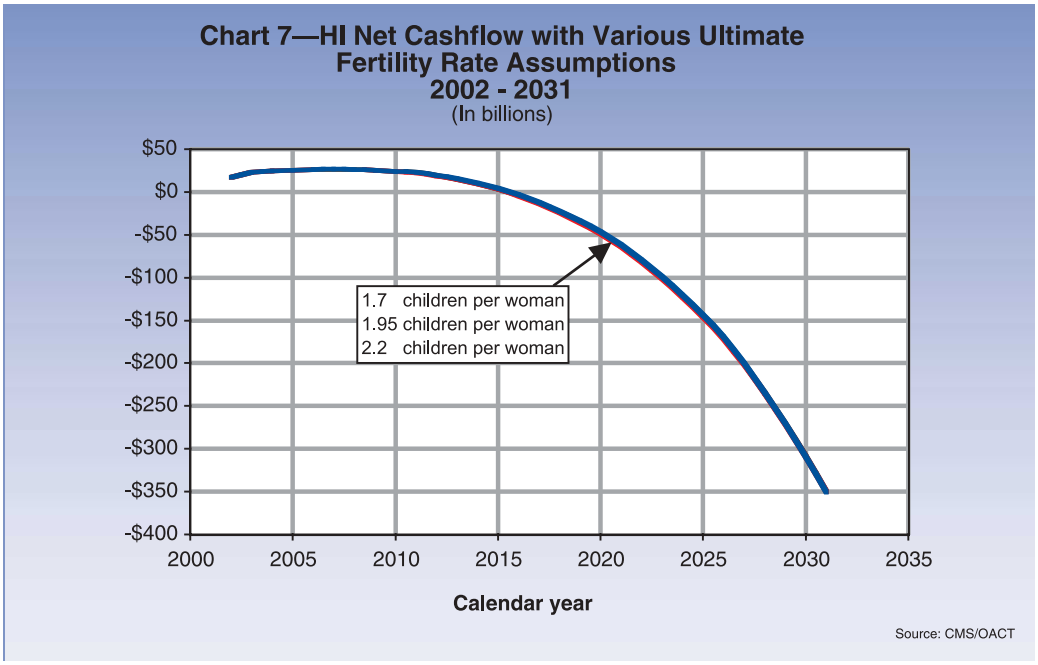
TABLE 3
Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.7	1.95	2.2
Income minus expenditures *(in billions)*	-$5,266	-$5,126	-$4,989

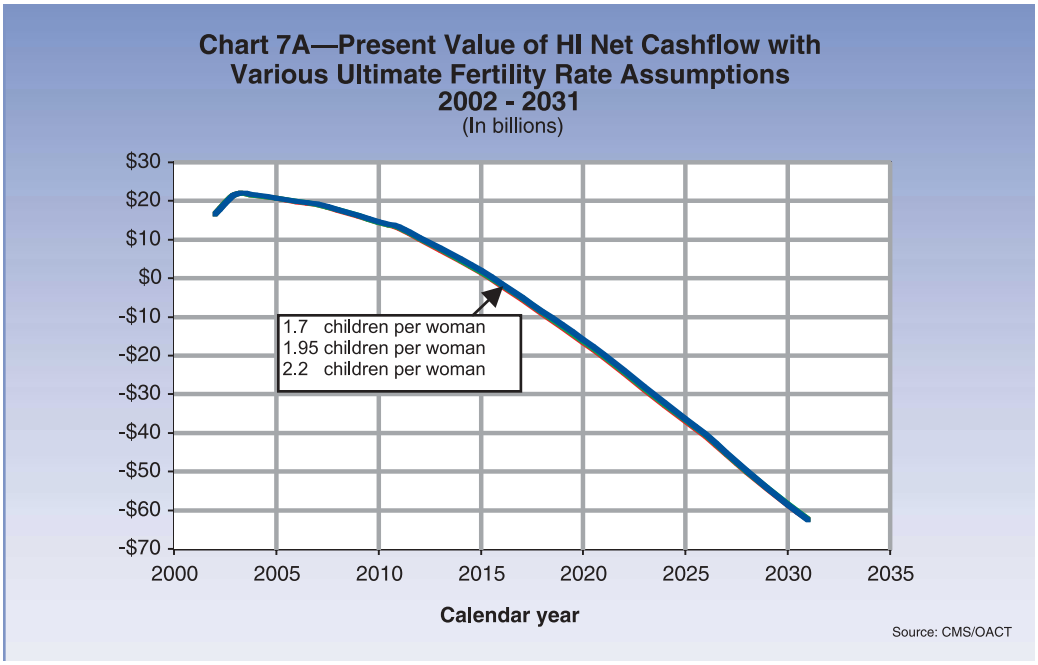
[1] The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year, and if she were to survive the entire childbearing period.

Table 3 demonstrates that if the assumed ultimate fertility rate is decreased from 1.95 to 1.7, the projected deficit of income over expenditures increases from $5,126 billion to $5,266 billion. On the other hand, if the ultimate fertility rate is increased from 1.95 to 2.2 children per woman, the deficit decreases to $4,989 billion.

Charts 7 and 7A show projections of the net cashflow under the three alternative fertility rate assumptions presented in table 3.



As charts 7 and 7A indicate, the fertility rate assumption has only a negligible impact on projected HI cashflows over the next 30 years. This is because higher fertility in the first year does not affect the labor force until roughly 20 years have passed (increasing HI payroll taxes slightly) and has virtually no impact on the number of beneficiaries within this period. Over the full 75-year period, the changes are somewhat greater, as illustrated by the present values in table 3.



Net Immigration

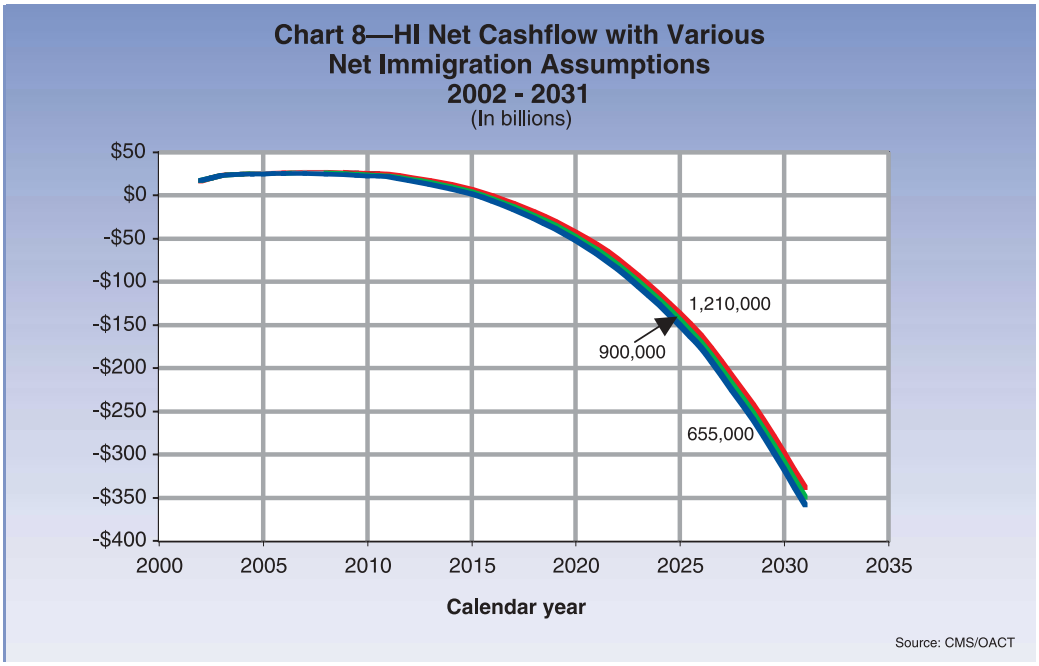
Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative net immigration assumptions: 655,000 persons, 900,000 persons, and 1,210,000 persons per year.

TABLE 4
Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

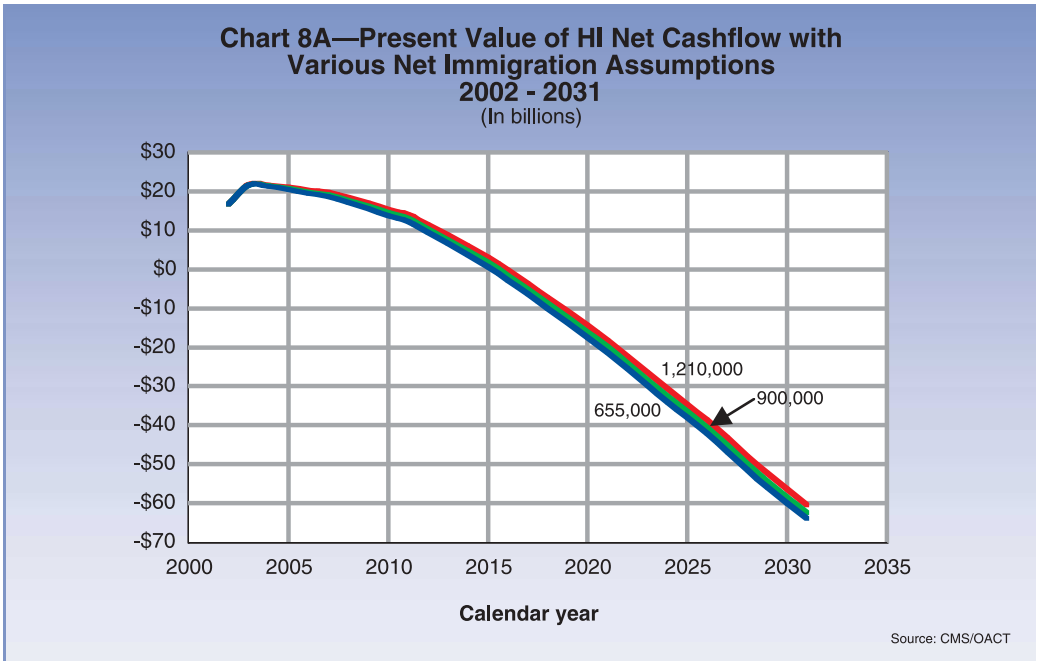
Ultimate net immigration	655,000	900,000	1,210,000
Income minus expenditures *(in billions)*	-$5,094	-$5,126	-$5,156

Table 4 demonstrates that if the ultimate net immigration assumption is decreased from 900,000 to 655,000 persons, the deficit of income over expenditures decreases from $5,126 billion to $5,094 billion. On the other hand, if the ultimate net immigration assumption is increased from 900,000 to 1,210,000 persons, the deficit increases to $5,156 billion.

Charts 8 and 8A show projections of the net cashflow under the three alternative net immigration assumptions presented in table 4.



As charts 8 and 8A indicate, this assumption has an impact on projected HI cashflow starting almost immediately. Because immigration tends to occur among younger individuals, the number of covered workers is affected immediately, while the



number of beneficiaries is affected much less quickly. Nonetheless, variations in net immigration result in fairly small differences in cashflow.

Real-Wage Differential

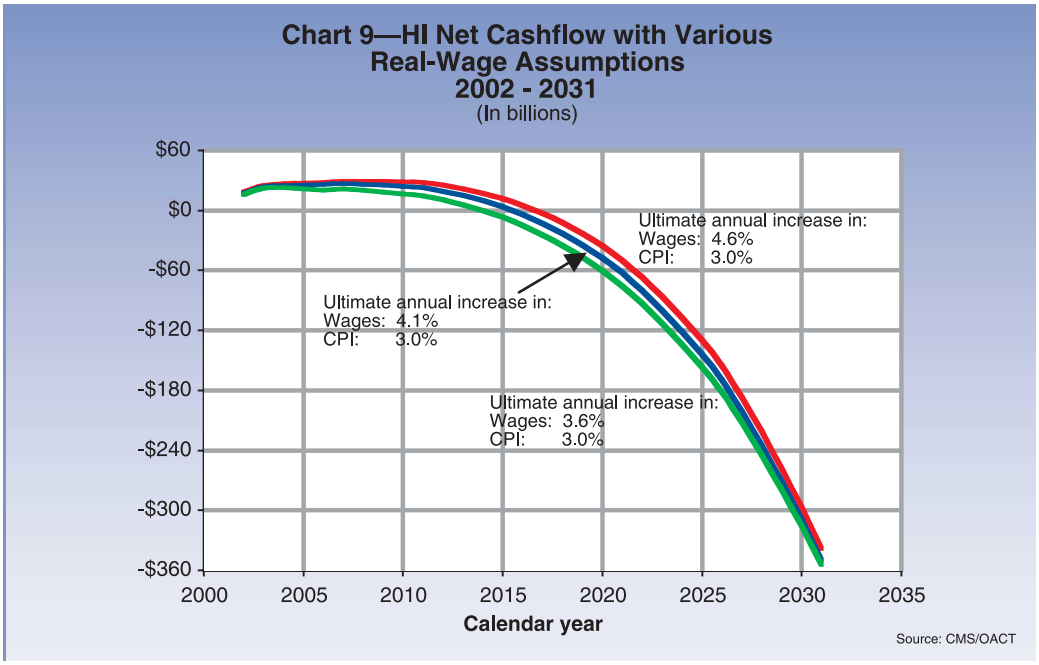
Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.1, and 1.6 percentage points. In each case, the CPI is assumed to be 3.0 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.6, 4.1, and 4.6 percent, respectively.

TABLE 5
Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

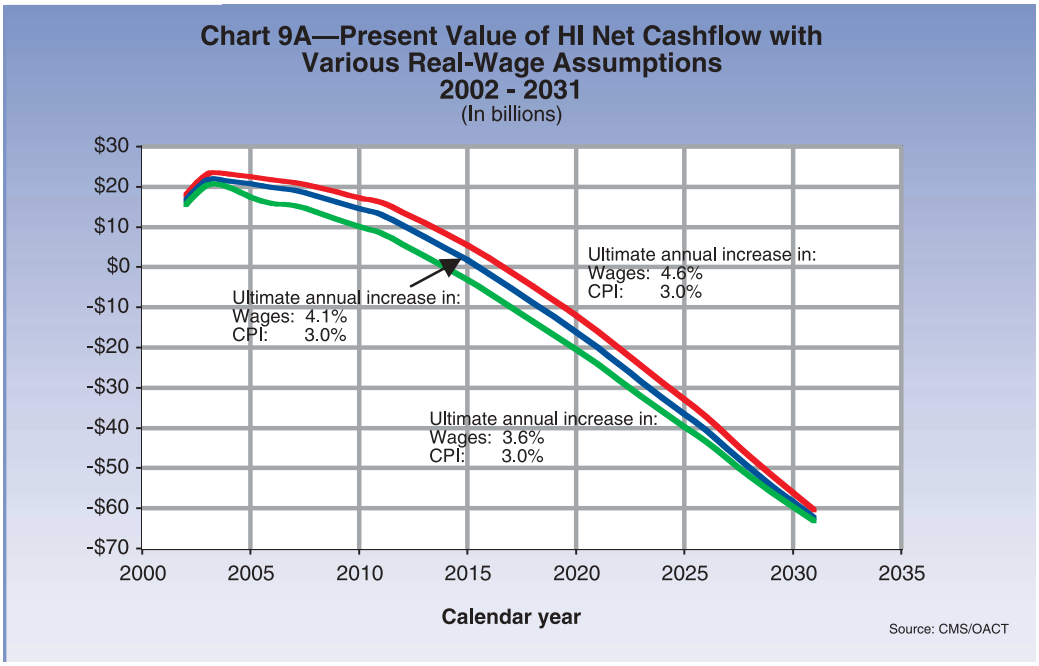
Ultimate percentage increase in wages - CPI	3.6 - 3.0	4.1 - 3.0	4.6 - 3.0
Ultimate percentage increase in real-wage differential	0.6	1.1	1.6
Income minus expenditures *(in billions)*	-$5,361	-$5,126	-$4,812

Table 5 demonstrates that if the ultimate real-wage differential assumption is decreased from 1.1 percentage points to 0.6 percentage point, the deficit of income over expenditures increases from $5,126 billion to $5,361 billion. On the other hand, if the ultimate real-wage differential assumption is increased from 1.1 percentage points to 1.6 percentage points, the deficit decreases to $4,812 billion.

Charts 9 and 9A show projections of the net cashflow under the three alternative real-wage differential assumptions presented in table 5.



As charts 9 and 9A indicate, this assumption has a fairly large impact on projected HI cashflow very early in the projection period. Higher real-wage differential assumptions immediately increase both HI expenditures for health care and wages for all workers. Though there is a full effect on wages and payroll taxes, the effect on benefits is only partial, since not all health care costs are wage-related.



Consumer Price Index

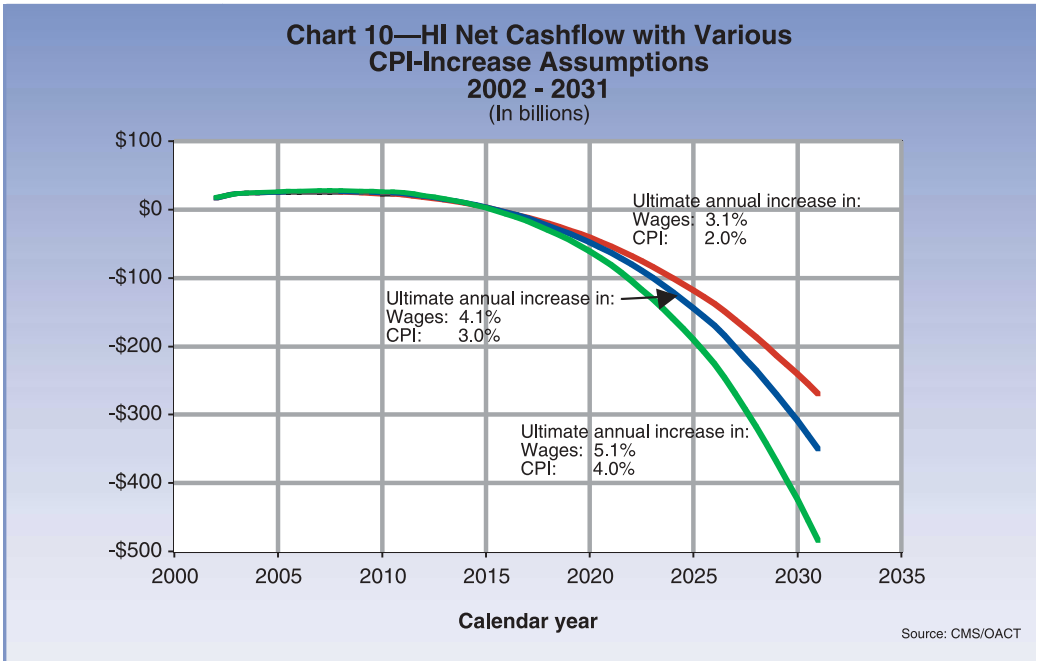
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 2.0, 3.0, and 4.0 percent. In each case, the ultimate real-wage differential is assumed to be 1.1 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.1, 4.1, and 5.1 percent, respectively.

TABLE 6
Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

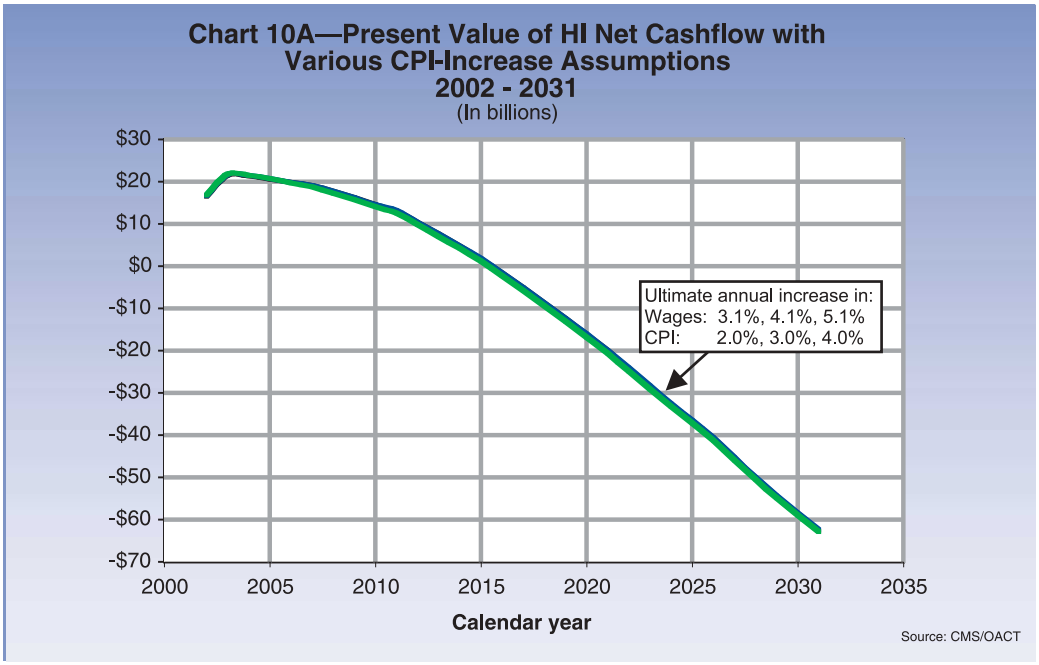
Ultimate percentage increase in wages - CPI	3.1 - 2.0	4.1 - 3.0	5.1 - 4.0
Income minus expenditures *(in billions)*	-$5,149	-$5,126	-$5,148

Table 6 demonstrates that if the ultimate CPI increase assumption is decreased from 3.0 percent to 2.0 percent, the deficit of income over expenditures increases from $5,126 billion to $5,149 billion. Furthermore, if the ultimate CPI increase assumption is increased from 3.0 percent to 4.0 percent, the deficit increases to $5,148 billion.

Charts 10 and 10A show projections of the net cashflow under the three alternative CPI rate-of-increase assumptions presented in table 6.



As charts 10 and 10A indicate, this assumption has a large impact on projected HI cashflow in nominal dollars but only a negligible impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cash-



flow to different levels of general inflation occurs because inflation tends to affect both income and costs equally. In nominal dollars, however, a given deficit "looks bigger" under high-inflation conditions but is not significantly different when it is expressed as a present value or relative to taxable payroll. This sensitivity test serves as a useful example of the limitations of nominal-dollar projections over long periods.

Real-Interest Rate

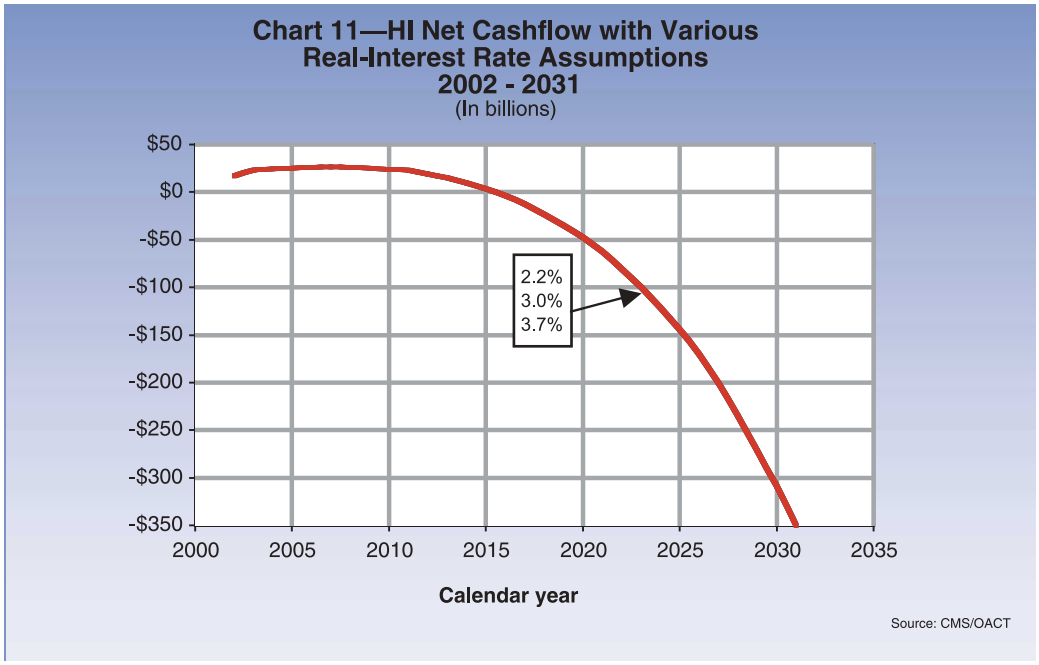
Table 7 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.2, 3.0, and 3.7 percent. In each case, the ultimate annual increase in the CPI is assumed to be 3.0 percent, resulting in ultimate annual yields of 5.2, 6.0, and 6.7 percent, respectively.

TABLE 7
Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions

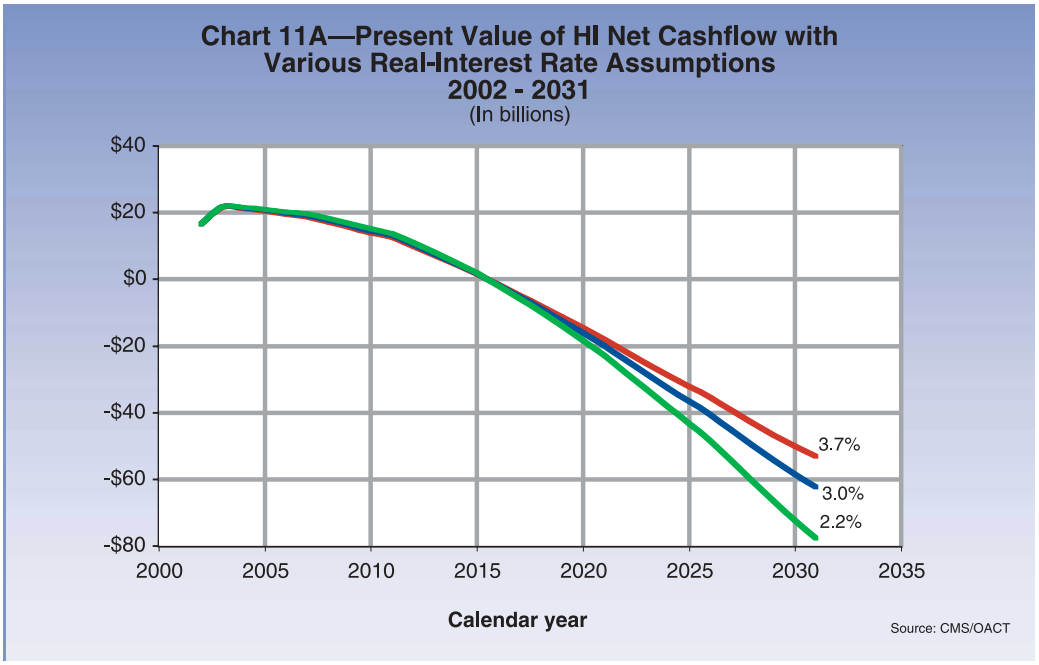
Ultimate real-interest rate	2.2 %	3.0 %	3.7 %
Income minus expenditures *(in billions)*	-$7,892	-$5,126	-$3,812

Table 7 demonstrates that if the ultimate real-interest rate percentage is decreased from 3.0 percent to 2.2 percent, the deficit of income over expenditures increases from $5,126 billion to $7,892 billion. On the other hand, if the ultimate real-interest rate assumption is increased from 3.0 percent to 3.7 percent, the deficit decreases to $3,812 billion.

Charts 11 and 11A show projections of the net cashflow under the three alternative real-interest assumptions presented in table 7.



As shown in charts 11 and 11A, the present values of the net cashflow are more sensitive to the interest assumption than is the nominal net cashflow. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2030. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), and the overall net present value is smaller.



Health Care Cost Factors

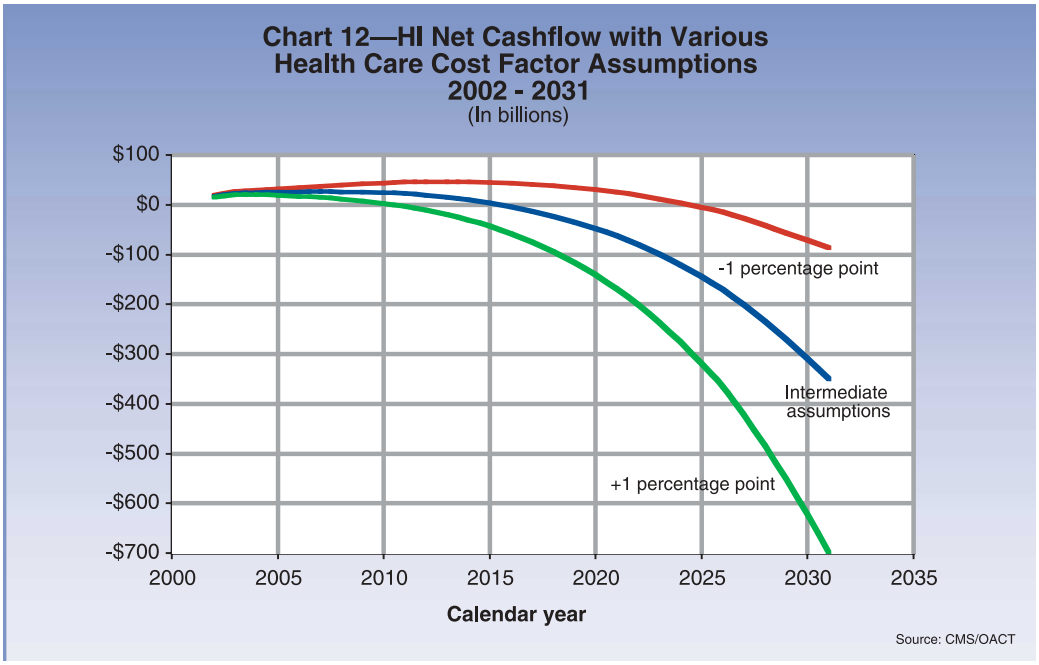
Table 8 shows the net present value of cashflow during the 75-year projection period under three alternative assumptions of the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as that which was assumed for the intermediate assumptions.

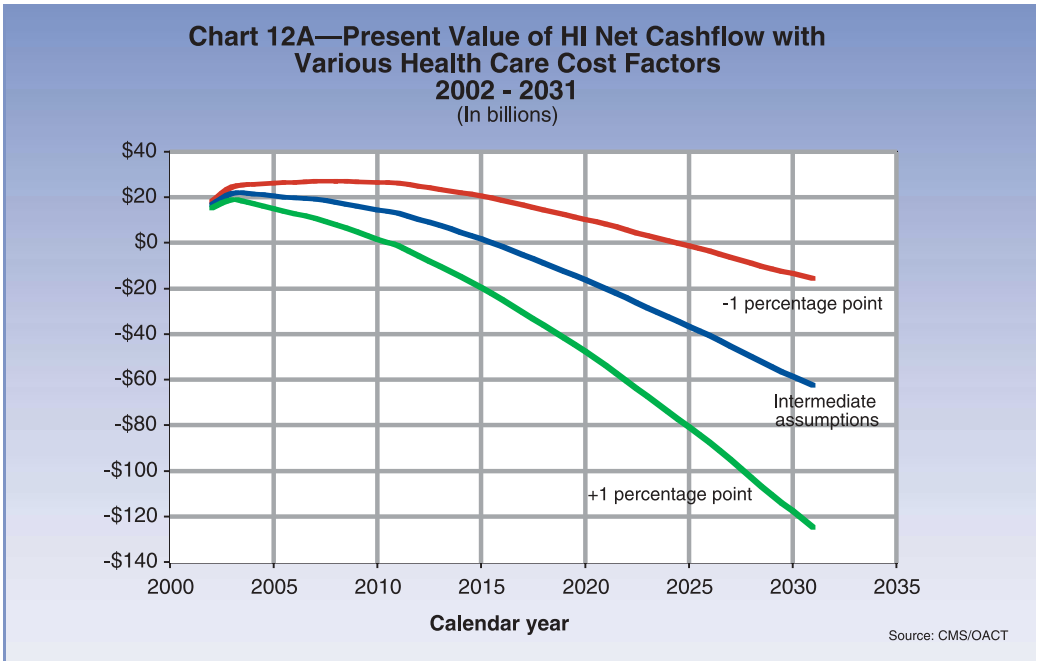
TABLE 8
Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+ 1 percentage point
Income minus expenditures *(in billions)*	-$906	-$5,126	-$12,047

Table 8 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit of income over expenditures decreases from $5,126 billion to $906 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially to $12,047 billion.

Charts 12 and 12A show projections of the net cashflow under the three alternative annual growth rate assumptions presented in table 8.





This assumption has a dramatic impact on projected HI cashflow. The assumptions analyzed thus far have affected HI income and costs simultaneously. However, several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As charts 12 and 12A indicate, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs versus taxable payroll.

TRUST FUND FINANCES AND SUSTAINABILITY

HI

The HI trust fund is substantially out of financial balance in the long range. Under the Medicare Trustees' intermediate assumptions, income is projected to continue to moderately exceed expenditures for the next 20 years but to fall short by steadily increasing amounts in 2022 and later. These shortfalls can be met by redeeming trust fund assets, but only until 2030.

To bring the HI trust fund into actuarial balance over the next 75 years under the intermediate assumptions, either outlays would have to be reduced by 38 percent or income increased by 60 percent (or some combination of the two) throughout the 75-year period. These substantial changes in income and/or outlays are needed in part as a result of the impending retirement of the baby boom generation.

The projections presented here indicate that without additional legislation, the fund would be exhausted in the future—initially producing payment delays, but very quickly leading to a curtailment of health care services to beneficiaries.

SMI

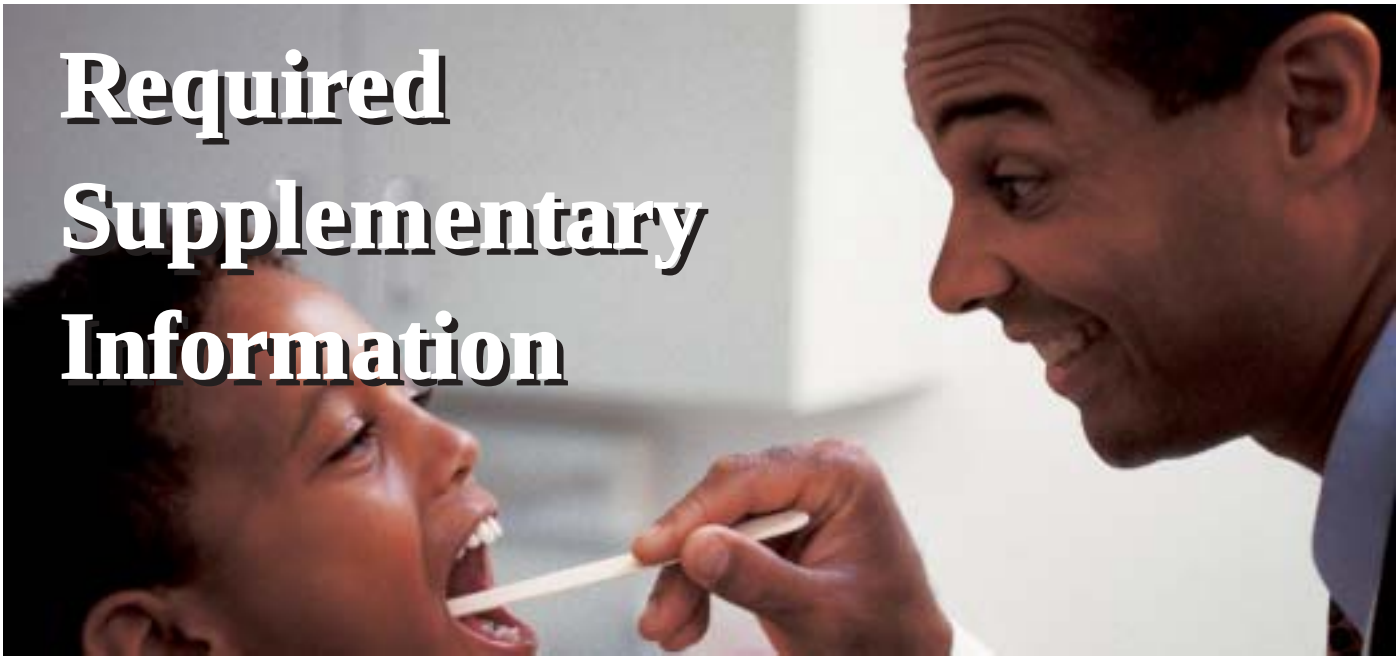
The financing established for the SMI trust fund for calendar year 2002 is estimated to be sufficient to cover expenditures for that year and to preserve an adequate contingency reserve in the fund. Moreover, for all future years, trust fund income is projected to equal expenditures—but only because beneficiary premiums and government general revenue contributions are set to meet expected costs each year.

The SMI trust fund's automatic financing provisions prevent crises such as those faced in recent years by the HI trust fund, the assets of which were projected to be exhausted in the near future. As a result, there has been substantially less attention directed toward the financial status of the SMI trust fund than to the HI trust fund—even though SMI expenditures have increased faster than HI expenditures in most years and are expected to continue to do so for a number of years in the future.

SMI costs have generally grown faster than the GDP, and this trend is expected to continue under present law. The projected increases are initially attributable in part to assumed continuing growth in the volume and intensity of services provided per beneficiary. Starting in 2011, the attainment of Medicare eligibility of the post-World War II baby boom generation will also have a major influence on the growth in SMI costs. This growth in SMI expenditures relative to GDP is a matter of great concern.

Medicare Overall

The projections shown in this section continue to demonstrate the need for the Administration and the Congress to address the financial challenges facing Medicare—both the remaining financial imbalance facing the HI trust fund and the continuing problem of rapid growth in SMI expenditures. In their 2002 annual report to Congress, the Medicare Boards of Trustees emphasize the seriousness of these concerns and urge the nation's policy makers to take "effective and decisive action…to build upon the strong steps taken in recent reforms." They also state: "Consideration of further reforms should occur in the relatively near future."



Required Supplementary Information

CONSOLIDATING BALANCE SHEET
As of September 30, 2002

(in millions)

	MEDICARE			HEALTH			Combined	Intra-CMS	Consolidated
	HI	SMI	Total	Medicaid	SCHIP	All Others	Totals	Eliminations	Totals
ASSETS									
Intragovernmental Assets:									
Fund Balance with Treasury	$162	$2,763	$2,925	$5,040	$10,933	$284	$19,182		$19,182
Trust Fund Investments	232,503	39,430	271,933				271,933		271,933
Accounts Receivable, Net	1,419	950	2,369	87	3	41	2,500	$(1,866)	634
Other Assets:									
Anticipated Congressional Appropriation				10,399			10,399		10,399
Total Intragovernmental Assets	**234,084**	**43,143**	**277,227**	**15,526**	**10,936**	**325**	**304,014**	**(1,866)**	**302,148**
Cash & Other Monetary Assets	77	298	375				375		375
Accounts Receivable, Net	1,703	966	2,669	891		52	3,612		3,612
General Property, Plant & Equipment, Net	2	7	9				9		9
Other	13	30	43	4		7	54		54
TOTAL ASSETS	**$235,879**	**$44,444**	**$280,323**	**$16,421**	**$10,936**	**$384**	**$308,064**	**$(1,866)**	**$306,198**
LIABILITIES									
Intragovernmental Liabilities:									
Accounts Payable	$1,037	$1,053	$2,090				$2,090	$(1,866)	$224
Accrued Payroll and Benefits	1	3	4			$1	5		5
Other Intragovernmental Liabilities	77	165	242	$2		68	312		312
Total Intragovernmental Liabilities	**1,115**	**1,221**	**2,336**	**2**		**69**	**2,407**	**(1,866)**	**541**
Federal Employee & Veterans' Benefits	3	7	10				10		10
Entitlement Benefits Due & Payable	14,106	14,130	28,236	16,340			44,576		44,576
Accrued Payroll & Benefits	19	34	53	3			56		56
Other Liabilities	48	153	201			11	212		212
TOTAL LIABILITIES	**15,291**	**15,545**	**30,836**	**16,345**		**80**	**47,261**	**(1,866)**	**45,395**
NET POSITION									
Unexpended Appropriations	3	3,014	3,017		$10,934	145	14,096		14,096
Cumulative Results of Operations	220,585	25,885	246,470	76	2	159	246,707		246,707
TOTAL NET POSITION	**$220,588**	**$28,899**	**$249,487**	**$76**	**$10,936**	**$304**	**$260,803**		**$260,803**
TOTAL LIABILITIES & NET POSITION	**$235,879**	**$44,444**	**$280,323**	**$16,421**	**$10,936**	**$384**	**$308,064**	**$(1,866)**	**$306,198**

REQUIRED SUPPLEMENTARY INFORMATION

CONSOLIDATING STATEMENT OF NET COST
For the Year Ended September 30, 2002
(in millions)

	MEDICARE			HEALTH			Combined	Intra-CMS	Consolidated
	HI	SMI	Total	Medicaid	SCHIP	All Others	Totals	Eliminations	Totals
NET PROGRAM/ACTIVITY COSTS									
GPRA Programs									
Medicare *(includes estimated improper payments of $8.2-$18.4 billion)*	$146,597	$84,535	$231,132				$231,132		$231,132
Medicaid				$150,101			150,101		150,101
SCHIP					$3,662		3,662		3,662
NET COST—GPRA PROGRAMS	**146,597**	**84,535**	**231,132**	**150,101**	**3,662**		**384,895**		**384,895**
Other Activities									
CLIA						$19	19		19
Ticket to Work Incentive						9	9		9
Other						1	1		1
NET COST—OTHER ACTIVITIES						**29**	**29**		**29**
NET COST OF OPERATIONS	**$146,597**	**$84,535**	**$231,132**	**$150,101**	**$3,662**	**$29**	**$384,924**		**$384,924**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2002
(in millions)

	MEDICARE			HEALTH			Consolidated
	HI	SMI	Total	Medicaid	SCHIP	All Others	Totals
CUMULATIVE RESULTS OF OPERATIONS							
Beginning Balances	$191,837	$31,516	$223,353	$16		$123	$223,492
Prior Period Adjustment	(212)	9	(203)	53	$2	38	(110)
Beginning Balances, as Adjusted	**191,625**	**31,525**	**223,150**	**69**	**2**	**161**	**223,382**
Budgetary Financing Sources:							
Appropriations Received							
Appropriations Transferred-in/out							
Other Adjustments							
Appropriations Used	9,062	76,726	85,788	149,916	3,656	8	239,368
Nonexchange Revenue	166,989	2,839	169,828				169,828
Transfers-in/out Without Reimbursement	(502)	(689)	(1,191)	190	6	19	(976)
Other Budgetary Financing Sources							
Other Financing Sources:							
Imputed Financing from Costs Absorbed by Others	8	19	27	2			29
TOTAL FINANCING SOURCES	**175,557**	**78,895**	**254,452**	**150,108**	**3,662**	**27**	**408,249**
NET COST OF OPERATIONS	**146,597**	**84,535**	**231,132**	**150,101**	**3,662**	**29**	**384,924**
ENDING BALANCES	**$220,585**	**$25,885**	**$246,470**	**$76**	**$2**	**$159**	**$246,707**
UNEXPENDED APPROPRIATIONS							
Beginning Balances	$3		$3		$11,475	$86	$11,564
Prior Period Adjustment				$110			110
Beginning Balances, as Adjusted	**3**		**3**	**110**	**11,475**	**86**	**11,674**
Budgetary Financing Sources:							
Appropriations Received	11,694	81,332	93,026	148,101	5,994	67	247,188
Appropriations Transferred-in/out				(990)	(60)		(1,050)
Other Adjustments	(2,632)	(1,592)	(4,224)	2,695	(2,819)		(4,348)
Appropriations Used	(9,062)	(76,726)	(85,788)	(149,916)	(3,656)	(8)	(239,368)
TOTAL FINANCING SOURCES		**3,014**	**3,014**	**(110)**	**(541)**	**59**	**2,422**
NET COST OF OPERATIONS							
ENDING BALANCES	**$3**	**$3,014**	**$3,017**		**$10,934**	**$145**	**$14,096**

COMBINING STATEMENT OF BUDGETARY RESOURCES
For the Year Ended September 30, 2002

(in millions)

	HI	SMI	HCFAC	Payments to Trust Funds	Program Mgmt.	Medicaid	SCHIP	Ticket to Work	HMO Loan	Combined Totals
Budgetary Resources:										
Budget Authority:										
Appropriations received	$179,737	$105,679		$93,026		$148,101	$5,994	$67		$532,604
Net transfers	(993)		$993			(990)	(60)			(1,050)
Unobligated Balance:										
Beginning of period			42	3	$194	110		40	$11	400
Spending authority from offsetting collections:										
Earned:										
Collected			7		60	26				93
Receivable from Federal sources						(26)				(26)
Change in unfilled customer orders:										
Advance received					5					5
Transfers from trust funds					2,386	2				2,388
SUBTOTAL	**178,744**	**105,679**	**1,042**	**93,029**	**2,645**	**147,223**	**5,934**	**107**	**11**	**534,414**
Recoveries of prior year obligations			16		182	4,198	2,858	2		7,256
Temporarily not available pursuant to Public Law	(31,543)	3,512								(28,031)
Permanently not available				(3)		(760)	(2,819)			(3,582)
TOTAL BUDGETARY RESOURCES	**$147,201**	**$109,191**	**$1,058**	**$93,026**	**$2,827**	**$150,661**	**$5,973**	**$109**	**$11**	**$510,057**
Status of Budgetary Resources:										
Obligations Incurred:										
Direct	$147,201	$109,191	$1,011	$90,009	$2,529	$150,661	$5,973	$27		$506,602
Reimbursable			3		94					97
SUBTOTAL	**147,201**	**109,191**	**1,014**	**90,009**	**2,623**	**150,661**	**5,973**	**27**		**506,699**
Unobligated Balance:										
Apportioned			7	3,017	46			81		3,151
Unobligated Balance not available			37		158			1	11	207
TOTAL STATUS OF BUDGETARY RESOURCES	**$147,201**	**$109,191**	**$1,058**	**$93,026**	**$2,827**	**$150,661**	**$5,973**	**$109**	**$11**	**$510,057**
Relationship of Obligations to Outlays:										
Obligated Balance, net, beginning of period	$818	$556	$185		$175	$5,332	$11,501	$20		$18,587
Obligated Balance, net, end of period:										
Accounts receivable					(1,144)					(1,144)
Undelivered orders	392	129	206		857		10,934	34		12,552
Accounts payable	576	793	7		68	5,049				6,493
Outlays:										
Disbursements	147,051	108,825	969	$90,009	2,403	146,882	3,682	11		499,832
Collections			(6)		(2,019)	(138)				(2,163)
SUBTOTAL	**147,051**	**108,825**	**963**	**90,009**	**384**	**146,744**	**3,682**	**11**		**497,669**
LESS: OFFSETTING RECEIPTS	**1,524**	**24,427**								**25,951**
NET OUTLAYS	**$145,527**	**$84,398**	**$963**	**$90,009**	**$384**	**$146,744**	**$3,682**	**$11**		**$471,718**

REQUIRED SUPPLEMENTARY INFORMATION

GROSS COST AND EXCHANGE REVENUE
For the Year Ended September 30, 2002

(in millions)

PROGRAM/ACTIVITY	INTRAGOVERNMENTAL						WITH THE PUBLIC		Consolidated
	Gross Cost			Less: Exchange Revenue			Gross	Less: Exchange	Net Cost of
	Combined	Eliminations	Consolidated	Combined	Eliminations	Consolidated	Cost	Revenue	Operations
NET PROGRAM/ACTIVITY COSTS									
GPRA Programs									
Medicare									
HI	$153		$153				$147,975	$1,531	$146,597
SMI	101		101				108,861	24,427	84,535
Medicaid	14		14				150,087		150,101
SCHIP	1		1				3,661		3,662
SUBTOTAL	**269**		**269**				**410,584**	**25,958**	**384,895**
Other Activities									
CLIA	10		10				68	59	19
Ticket to Work Incentive							9		9
Other				$1		$1	2		1
SUBTOTAL	**10**		**10**	**1**		**1**	**79**	**59**	**29**
PROGRAM/ACTIVITY TOTALS	**$279**		**$279**	**$1**		**$1**	**$410,663**	**$26,017**	**$384,924**

CONSOLIDATED INTRAGOVERNMENTAL BALANCES
For the Year Ended September 30, 2002

(in millions)

	*TFM Dept. Code	Fund Bal. with Treasury	Investments	Accounts Receivable	Other
INTRAGOVERNMENTAL ASSETS					
Agency					
Department of the Treasury	20	$19,182	$271,933		$10,399
Department of Defense	17, 21 57, 97			$123	
All Other Federal Agencies				511	
		$19,182	**$271,933**	**$634**	**$10,399**

	*TFM Dept. Code	Accounts Payable	Environmental & Disposal Costs	Accrued Payroll & Benefits	Other
INTRAGOVERNMENTAL LIABILITIES					
Agency					
Department of Justice	15				$1
Department of Labor	16			$2	
Department of the Treasury	20				269
Office of Personnel Management	24			3	
Social Security Administration	28	$224			
General Services Administration	47				11
Department of Health and Human Services	75				3
All Other Federal Agencies					28
		$224		**$5**	**$312**

	*TFM Dept. Code	Earned Revenue	Gross Cost	Non-exchange Revenue Transfers-in	Transfers-out
INTRAGOVERNMENTAL REVENUES & EXPENSES					
Agency					
Department of Commerce	13		$1		
Department of Justice	15		101		
Department of Labor	16		2		
Department of the Treasury	20		1		
Department of Defense	17, 21 57, 97		(29)	$81	
Office of Personnel Management	24		76		
Social Security Administration	28			2	$(1,405)
General Services Administration	47		45		
Railroad Retirement Board	60			373	(5)
Department of Transportation	69				
Department of Health and Human Services	75	$1	46		(14)
All Other Federal Agencies			36		(8)
		$1	**$279**	**$456**	**$(1,432)**

* Treasury Financial Manual

Audit Opinion and Management Response

Department of Health and Human Services

CENTERS FOR MEDICARE & MEDICAID SERVICES

JAN 22 2003

TO: Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

FROM: Janet Rehnquist
Inspector General

SUBJECT: Report on the Financial Statement Audit of the Centers for Medicare and Medicaid Services for Fiscal Year 2002 (A-17-02-02002)

The attached final report presents the results of the audit of the fiscal year (FY) 2002 financial statements of the Centers for Medicare and Medicaid Services (CMS). We contracted with Ernst & Young LLP (E&Y), an independent certified public accounting firm, to perform the CMS audit, which supports the departmentwide audit by the Office of Inspector General (OIG) in accordance with the Government Management Reform Act of 1994.

The audit objectives were to determine whether (1) the CMS consolidated balance sheets as of September 30, 2002 and 2001, and the related consolidated statements of net costs for the FYs then ended, as well as the consolidated statement of changes in net position, consolidated statement of financing, and combined statement of budgetary resources for the FY ended September 30, 2002, were fairly presented in all material respects; (2) CMS internal controls provided reasonable assurance that transactions were properly recorded and accounted for to permit the preparation of reliable financial statements; and (3) CMS complied with laws and regulations that could have a direct and material effect on the financial statements.

We evaluated the nature, timing, and extent of the work, monitored progress throughout the audit, reviewed E&Y's documentation, met with partners and staff members, evaluated the key judgments, met with officials of CMS, performed independent tests of the accounting records, and performed other procedures we deemed appropriate in the circumstances. We conducted our work in accordance with auditing standards generally accepted in the United States.

We concur with E&Y's report, which indicated that:

- The financial statements referred to above present fairly, in all material respects, the financial position of CMS as of September 30, 2002 and 2001, and its net costs for the years then ended, as well as the changes in net position, budgetary resources, and reconciliation of net costs to budgetary obligations for FY 2002 in conformity with accounting principles generally accepted in the United States;

- Certain matters involving internal controls over financial reporting were considered to be reportable, two of which were deemed to be material weaknesses under standards issued by the American Institute of Certified Public Accountants.

- The CMS financial management systems, in some instances, did not substantially comply with certain requirements referred to in the Federal Financial Management Improvement Act of 1996.

The CMS is commended for sustaining the unqualified audit opinion first issued on the FY 1999 financial statements. While substantial progress has been made in providing reliable financial information, CMS continues to be impaired by the absence of a fully integrated financial management system to accumulate, analyze, and report financial information in a timely manner. As discussed in the auditor's report on internal controls, material weaknesses continue in financial systems, analyses, and oversight and in Medicare electronic data processing (EDP) controls.

Financial Systems, Analyses, and Oversight (Partial Repeat Condition). As reported in FY 2001 and continuing in FY 2002, the Medicare contractors' claim processing systems did not have general ledger capabilities, and limited system interfaces were available to process and prepare data for CMS. The contractors' lack of integrated, double-entry systems and use of ad hoc supporting schedules increased the risk that their reported information could be inconsistent, incomplete, or inaccurate. Also, independent verification controls needed further enhancements to provide assurance that amounts reported by contractors to CMS were valid, accurately summarized, and sufficiently documented. In addition, accounts receivable control deficiencies continued at the contractors.

During FY 2002, we noted much improvement in the central and regional offices' financial analysis and oversight of the contractors' financial management practices. However, certain processes still needed strengthening to provide reasonable assurance of detecting and correcting material errors in a timely manner. The CMS should continue to enhance its oversight of information included in the financial statements, and the regional offices should perform certain procedures to ensure that the contractors' financial data are reliable, accurate, and complete.

Medicare Electronic Data Processing Controls (Repeat Condition). The CMS relies on extensive, interdependent EDP operations at both its central office and Medicare contractor sites to administer the Medicare program and to process and account for Medicare expenditures. Adequate internal controls over these operations are essential to the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. In FY 2002, we continued to find numerous EDP general control weaknesses at the Medicare contractors, system maintainers, and the CMS central office. Such weaknesses increase the risk of (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy files, (3) improper Medicare payments, and (4) disruption of critical operations.

The CMS comments on the draft of this report have been incorporated where appropriate. Officials in your office have concurred with the recommendations and are in the process of taking corrective action.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me or David M. Long, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through e-mail at dlong@oig.hhs.gov. To facilitate identification, please refer to report number A-17-02-02002 in all correspondence.

Attachment

cc:
Kerry N. Weems
Acting Assistant Secretary for
Budget, Technology, and Finance

George H. Strader
Deputy Assistant Secretary, Finance

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Report of Independent Auditors

To the Inspector General of the
Department of Health and Human Services, and
the Administrator of the Centers for Medicare & Medicaid Services

We have audited the consolidated balance sheets of the Centers for Medicare & Medicaid Services (CMS), an operating division of the Department of Health and Human Services as of September 30, 2002 and 2001, and the related consolidated statements of net costs for the fiscal years then ended and the consolidated statement of changes in net position and financing and combined statement of budgetary resources for the fiscal year ended September 30, 2002. These financial statements are the responsibility of the CMS' management. Our responsibility is to express an opinion on these financial statements based on our audits. The Health Programs, a major subset of CMS administered programs, had total assets of $27.7 billion and $25.2 billion as of September 30, 2002 and 2001 and total net costs of $153.8 billion and $133.0 billion for the years then ended. The financial information for the Health Programs, which are included in CMS' consolidated and combined financial statements, were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for the Health Programs, is based solely on the report of other auditors.

We conducted our audits for the years ended September 30, 2002 and 2001 in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 01-02, *Audit Requirements for Federal Financial Statements*. These standards and requirements require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits and the report of other auditors provide a reasonable basis for our opinion.

In our opinion, based on our audits and the report of other auditors, the financial statements referred to above present fairly, in all material respects, the financial position of the CMS as of September 30, 2002 and 2001, and its net costs for the years then ended, and the changes in net position, budgetary resources, and its reconciliation of net costs to budgetary obligations for the fiscal year then ended September 30, 2002, in conformity with accounting principles generally accepted in the United States.

Our audits were conducted for the purpose of expressing an opinion on the basic financial statements taken as a whole. The information presented in the Management's Discussion and Analysis (MD&A) and the Supplemental Information is not a required part of the CMS' financial statements, but is considered supplementary information required by OMB Bulletin 01-09, *Form and Content of Agency Financial Statements*. Such information has not been subjected to the auditing procedures applied by us and the other auditors in the audit of the financial statements, and accordingly, we express no opinion on it.

In accordance with *Government Auditing Standards*, we have also issued our reports dated December 10, 2002, on our consideration of the CMS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audits.

Ernst + Young LLP

December 10, 2002

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Report of Independent Auditors on Compliance with Laws and Regulations

To the Inspector General of the
Department of Health and Human Services, and
the Administrator of the Centers for Medicare & Medicaid Services

We have audited the financial statements of the Centers for Medicare & Medicaid Services (CMS), an operating division of the Department of Health and Human Services, as of September 30, 2002, and have issued our report thereon dated December 10, 2002. The Health Programs, a major subset of CMS administered programs, had total assets of $27.7 billion and $25.2 billion as of September 30, 2002 and 2001, and total net costs of $153.8 billion and $133.0 billion for the years then ended. The financial information for the Health Programs, which are included in CMS' consolidated and combined financial statements, were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for the Health Programs, is based solely on the report of other auditors.

We have conducted our audits in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*.

The management of the CMS is responsible for complying with laws and regulations applicable to the CMS. As part of obtaining reasonable assurance about whether the CMS' financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts and certain other laws and regulations specified in OMB Bulletin 01-02, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA). We limited our tests of compliance to these provisions and we did not test compliance with all laws and regulations applicable to the CMS.

The results of our tests and the tests of other auditors disclosed no instances of noncompliance with the laws and regulations discussed in the preceding paragraph exclusive of FFMIA that are required to be reported under *Government Auditing Standards* or OMB Bulletin 01-02.

Under FFMIA, we are required to report whether the CMS' financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a) requirements.

The results of our tests and the tests of other auditors disclosed instances in which the CMS' financial management systems did not substantially comply with certain requirements discussed in the preceding paragraph. We have identified the following instances of noncompliance.

- CMS does not have an integrated accounting system to capture expenditures at the Medicare contractor level, and certain aspects of the existing financial reporting system does not conform to the requirements currently specified by the Joint Financial Management Improvement Program.

- Weaknesses identified in CMS' Central Office and Medicare financial management systems' access and application controls are significant departures from requirements specified in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

As reported by CMS in Footnote 10 to the financial statements referenced above, certain claims submitted by providers do not comply with Medicare laws and regulations.

The Report of Independent Auditors on Internal Control and our separate management letter includes information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the noncompliance, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented, and that relevant comments from the CMS' management responsible for addressing the noncompliance are provided as an attachment to this report.

Providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit and, accordingly, we do not express such an opinion.

This report is intended solely for the information and use of the management of CMS and the Department of Health and Human Services, OMB, and Congress, and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

December 10, 2002

ERNST & YOUNG

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Report of Independent Auditors on Internal Control

To the Inspector General of the
Department of Health and Human Services, and
the Administrator of the Centers for Medicare & Medicaid Services

We have audited the financial statements of the Centers for Medicare & Medicaid Services (CMS), an operating division of the Department of Health and Human Services (HHS) as of September 30, 2002, and have issued our report thereon dated December 10, 2002. The Health Programs, a major subset of CMS administered programs, had total assets of $27.7 billion and $25.2 billion as of September 30, 2002 and 2001, and total net costs of $153.8 billion and $133.0 billion for the years then ended. The financial information for the Health Programs, which are included in CMS' consolidated and combined financial statements, were audited by other auditors whose report has been furnished to us, and our opinion and the comments related herein, insofar as they relate to the Health Programs, are based solely on the report of other auditors.

We conducted our audits in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 01-02, *Audit Requirements for Federal Financial Statements*.

In planning and performing our audits, we considered CMS' internal control over financial reporting by obtaining an understanding of the agency's internal control, determined whether internal control had been placed in operation, assessed control risk, and performed tests of controls in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin 01-02. We did not test all internal control relevant to operating objectives as broadly defined by the Federal Managers Financial Integrity Act, such as those controls relevant to ensuring efficient operations. The objective of our audits was not to provide assurance on internal control. Consequently, we do not provide an opinion on internal control.

Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be reportable conditions. Under standards issued by the American Institute of Certified Public Accountants, reportable conditions are matters coming to our attention relating to significant deficiencies in the design or operation of the internal control that, in our judgment, could adversely affect the CMS' ability to record, process, summarize, and report financial data consistent with the assertions by management in the financial statements. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Because of inherent limitations in internal control, misstatements, losses, or noncompliance may nevertheless occur and not be detected. However, we noted certain matters discussed in the following paragraphs involving the internal control and its operation that we consider to be reportable conditions. We consider both matters noted—Financial Systems, Analyses and Oversight and Medicare Electronic Data Processing (EDP) Controls—to be material weaknesses.

MATERIAL WEAKNESSES

Financial Systems, Analyses and Oversight (Partial Repeat Condition)

Overview

OMB Circular A-127 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal control, and reliable data. The CMS relies on a decentralized organization, complex and antiquated systems and ad hoc reporting to accumulate data for financial reporting due to the lack of an integrated financial accounting system at the contractor level. During fiscal year (FY) 2002, CMS contracted with approximately 47 contractors to manage and administer the Medicare program. On a monthly basis, the contractors submit various "Contractor Financial Reports" to CMS for its management and monitoring of the Medicare activities.

The CMS continues to work towards resolving this material weakness, noted in the FY 2001 and prior financial statement audit reports, related to the lack of an integrated financial management system and inadequate financial accounting and supervisory review processes over its more than $231 billion in Medicare expenditures for FY 2002. Management reported certain actions, including:

- Issuing the Chief Financial Officer (CFO) FY 2002 Comprehensive Plan for Financial Management and the associated project plans, which identified milestones and activities for achieving the comprehensive plan goals and initiatives.

- Completing the automated applications for preparing all five required principal financial statements and developing and implementing trending analyses procedures at the line item level for each financial statement.
- Performing Statement on Auditing Standards (SAS) 70 reviews documenting and assessing internal controls at 17 Medicare contractor sites. These reviews include assessing contractors' progress in implementing corrective actions for prior audits. Fifteen of the contractors also received reviews of accounts receivable balances.
- Referring an additional $1.4 billion of delinquent debt to the Treasury during FY 2002 as a result of efforts of the debt referral process.
- Providing comprehensive instructions to the Medicare contractors and the CMS central office and regional offices through formal guidance and training conferences, which included promoting a uniform method of reporting and accounting for accounts receivable and related financial data. In addition, CMS central and regional office staff received training on a 1522 review protocols, which were used at six Medicare contractor locations.
- Establishing workgroups comprised of central office and regional office consortia staff to serve as subject matter experts responsible for addressing four key areas: follow up on corrective action plans (CAPs), reconciliations of funds expended to paid claims, trend analyses, and internal controls. The objectives of each workgroup are to clearly define central and regional office roles and responsibilities, as well as to develop the national strategic plans to strengthen Medicare contractor financial management oversight in these areas.
- Developing and maintaining contractor accounts receivable trend analysis procedures and using formal procedures for financial reporting analysis.
- Developing and maintaining procedures for regional office review of contractor trend analysis.
- Conducting policy review and implementing a protocol to review contractors' annual Certification Packages for Internal Controls (CPIC) submissions.
- Finalizing Healthcare Integrated General Ledger Accounting System (HIGLAS) management plans and beginning "Conference Room Pilots" for pilot contractors.
- Beginning design and building of HIGLAS functional environment for the pilots.
- Identifying additional Medicare contractor shared system changes.
- Revising the Financial Management Manual for Medicare contractors and making it available on the Internet.
- Finalizing and issuing the remaining chapters of the accounting procedures manual, which was completed in October 2002.
- Creating hundreds of accounting transactions to facilitate the United States Standard General Ledger requirements.

While progress was made in upgrading its systems, improving its policies and procedures, and implementing trending procedures of its regional office and contractor financial reports, financial management issues continue to impair CMS' ability to accumulate, analyze, and distribute reliable financial information. Our review of the internal control at the CMS central office,

regional offices, and selected Medicare contractors disclosed weaknesses in CMS' ability to report accurate financial information on a timely basis. These weaknesses are primarily due to the absence of certain components of a fully integrated financial management system; that such absences include full accrual accounting, a double-entry general ledger system and appropriate oversight. Currently, Medicare contractors do not utilize uniform accounting systems that record, classify, and summarize information for the preparation of financial statements. Integrated financial systems, a sufficient number of properly trained personnel, and a strong oversight function are needed to ensure periodic analyses and reconciliations are completed to detect and resolve errors and irregularities in a timely manner.

Lack of Integrated Financial Management System

The CMS' financial management systems are not compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA). FFMIA requires agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements as defined by the Joint Financial Management Improvement Program (JFMIP). More specifically, FFMIA requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems. The lack of an integrated financial management system continues to impair CMS' and the Medicare contractors' abilities to adequately support and analyze accounts receivable and other financial balances reported.

As reported in FY 2001 and continuing in FY 2002, the Medicare contractors' claims processing systems do not have general ledger capabilities, and there are limited system interfaces currently available and in use to process and prepare data for the CMS 750/751 reports. The CMS 750 /751 reports prepared by the contractors are the culmination of the transactions and activity that have transpired from the beginning of the fiscal year. Contractors monitor and track accounts receivable activity using claims processing systems, personal computer based software, and ad-hoc spreadsheet applications to tabulate, summarize and prepare the information presented on the CMS 750/751 reports.

Because the claim processing systems utilized by the Medicare contractors lack general ledger capabilities, preparing the CMS 750/751 reports is a labor intensive exercise requiring significant manual input and reconciliations between various systems and ad-hoc spreadsheet applications. The lack of double-entry systems coupled with the increased use of ad-hoc supporting schedules are contributing factors that increase the risk that contractors may report inconsistent, incomplete, or inaccurate information.

During FY 2002, CMS continued its efforts in its implementation of its HIGLAS for the contractor, regional office, and central office locations. HIGLAS is intended to be an integrated general ledger accounting system, which incorporates Medicare contractors' financial data including claims activity into CMS' internal accounting system. As part of this effort, CMS is also replacing its central office general ledger that accumulates all of CMS' financial activities, both programmatic and administrative, in its general ledger. Once implemented, the new system is

expected to strengthen Medicare's management of its accounts receivable, allow more timely and effective collection activities on outstanding debts and enhance oversight of contractor accounting systems. HIGLAS is expected to be fully operational in FY 2007.

Financial Analyses and Reporting—Medicare Contractors

Although our overall results identified improvements during FY 2002 in internal control processes, our review of internal control at selected Medicare contractors, coupled with the results of CMS' accounts receivable review at 15 Medicare contractors as of March 31, 2002, disclosed a series of weaknesses that impact CMS' ability to report accurate financial information. Because the contractors lack a formal integrated accounting system to accumulate and report financial information, the contractors are using ad-hoc reports, which are very labor intensive to develop and utilize and increase the risk of human error and material misstatement. We found that independent verification controls need further enhancements to provide assurance that amounts reported by contractors to CMS were valid, accurately summarized and sufficiently documented.

Medicare Contractor Accounts Receivable

At September 30, 2002, CMS reported a net Medicare accounts receivable balance of approximately $2.7 billion, comprised of gross outstanding accounts receivable of $7.0 billion and an aggregate allowance for uncollectible accounts of $4.3 billion. Of the $7.0 billion, CMS contractors are responsible for reporting and collecting the majority of these receivables ($5.1 billion or over 73% of the outstanding balance at year-end.) The majority of these receivables (referred to as Non-Medicare Secondary Payer (Non-MSP)) represent contractor overpayments to providers, beneficiaries, physicians, and suppliers. The balance of the contractor-related receivables represents payments for those claims for which there are initial indications that Medicare should be the secondary rather than the primary payer (referred to as MSP). The remaining Medicare accounts receivable activity is managed by CMS' central and regional offices.

The CMS continues to refine its processes and update its systems at the contractors; however, certain weaknesses in internal control persist. Our review of accounts receivable at eight contractors identified similar control deficiencies as compared to those reviews performed at September 30, 2001 and CMS' review of Medicare contractor accounts receivables at March 31, 2002. For example, our review of accounts receivable activities at September 30, 2002, identified the following:

- At one contractor, a detailed subsidiary ledger could not be provided to support the aging balances per the contractor report.
- At another contractor, no aging of accounts receivable was performed.

- One contractor had $18.3 million of MSP receivables that were older than 180 days old; however, these transactions had not been identified as currently not collectible in accordance with CMS policy.
- We noted that one contractor could not provide documentation to support $1.4 million of the $3.3 million balance in MSP adjustments.
- At two contractors, we noted clerical errors were the cause of misstatements to accounts receivable. At one contractor, a clerical error caused a reclassification error between funds of $3.3 million while at the other an input error caused an overstatement of $1 million to cost settlement receivables.
- At one contractor, we noted that detailed documentation was not available to support $26 million in offsets of collections. As a result, we were unable to determine if amounts were properly offset against the respective accounts receivable.
- We noted at two contractors that cash receipts were not being recorded timely against existing receivables. At one contractor, 10 of 30 receipts selected for testing were not applied to the appropriate receivable in a timely manner—for four cases, the receipt took over four months to be applied properly.

Medicare Contractors Reconciliation of Funds Expended

The reconciliation of "total funds expended" on the CMS-1522, Monthly Contractor Financial Report, is an important control that ensures amounts reported to CMS on this report by Medicare contractors are accurate, supported, complete, and properly classified. At the contractor level, "total funds expended" is the sum of all checks drawn and electronic fund transfer payments issued during the calendar month less voided checks and overpayment recoveries. This amount is then classified by component into the following categories: benefit payments, periodic interim payments, accelerated payments, net suspense payments, audit reimbursement adjustments, and interest income and expenses. The CMS uses certain information from this report to support the Medicare payment error rate and the Medicare entitlement benefits due and payable included in the financial statements.

The CMS requires the monthly reconciliations to be performed using the actual paid claims tapes or related systems summary reports. If the contractors shared system can produce a claims paid tape, the Medicare contractors are required, by Program Memorandum CR 1330, to generate and retain claims paid tapes for reconciliation purposes. For FY 2002, five of the eight Medicare contractors in our sample should have generated and retained claims paid tapes. However, all five contractors experienced problems recreating the claims paid tape. Subsequently, the claims paid tape were generated for our reconciliation. The reconciliations are critical because the auditors must be able to obtain a file of paid claims that reconciles to the CMS-1522 as a requirement for selecting a statistically valid sample of claims. Moreover, the reconciliations constitute a key internal control whereby documentation should be maintained. Our review of the CMS-1522 reconciliations identified the following deficiencies at three of the eight selected Medicare contractors in FY 2002.

- At one of the contractors, the reconciliation process did not compare the funds expended amount reported on the CMS-1522. Because the reconciliation was not performed properly, the contractor did not have assurance that its total funds expended figure reported to CMS was accurate. As a result of a computer conversion problem, the contractor understated total expended funds for January 2002 by $4.3 million.
- At another contractor, we determined a difference between the paid claims tapes and the supporting financial data in the amount of $175,000, which resulted from a recent implementation of the contractor's full claims adjustment process. The Office of Inspector General (OIG) plans a nationwide review that will follow-up on this finding, to determine if the deficiency represents a systemic problem in the contractors shared processing systems.
- At the third contractor, we found similar conditions that existed during our FY 2000 audit, particularly the errors to the amounts reported for the outstanding checks balances, other adjustments and monthly interest adjustment. Other reconciliation errors were identified as a result of financial adjustments processed when the contractor transitioned from one bank to another.

Financial Oversight and Reporting—Central and Regional Offices

During FY 2002, although much improvement has been noted in the central and regional financial analysis and oversight functions of the contractors' financial management practices, we continue to identify certain processes that should be strengthened to provide reasonable assurance that material errors would be detected and corrected in a timely manner.

CMS Central Office

During FY 2002, CMS continued to build upon prior efforts to improve its oversight of Medicare contractors and the regional offices. Central office's continuing efforts for FY 2002, included:

- providing additional guidance to the contractor and regional office community,
- implementing quarterly procedures related to performing or reviewing trend analysis to validate the accuracy and completeness of financial data reported by Medicare contractors and regional offices, and
- finalizing the new financial accounting policies manual that was completed in October 2002.

The CMS' Central Office should, however, continue to enhance its review of information included in its financial statements. We noted the following weaknesses during our review:

- Supervisory reviews were not consistently performed and documented. We noted several computational errors that could have been identified with the appropriate level of detailed supervisory reviews.

  - Within the footnotes, $238 million in managed care payments were misrepresented as fee for service payments due to miscommunication within CMS about the creation of new codes within the general ledger to track managed care demo payments separately.
  - We noted differences of $28.5 billion in SMI and $3.3 billion in HI between CMS and the Treasury records whereby CMS did not close out general ledger accounts properly by recording open balances as budget authority on the statement of budgetary resources instead of appropriations temporarily not available.
  - During our review of the central office spreadsheets calculating the contractor MSP accounts receivable, we noted that the non-current amounts of $2.4 million were manually input as negative amounts rather than positive amounts. As a result, accounts receivable balances were misstated by $4.8 million. Additionally, we noted the exclusion of $1.4 million of the allowance related to SMI.
- Differences were reported where (1) a $2.8 million difference was identified between claims on the payment floor amounts reported to CMS and detailed support maintained at one contractor; (2) $8.9 million of $9 million in unprocessed claims were unsupported; and (3) periodic interim payment where amounts reported by the contractor to CMS did not agree to supporting documentation maintained at the contractors.
- System Tracking of Audit and Reimbursement (STAR) data, which are CMS' primary source for cost settlement information, are inconsistent with cost settlement information that is recorded on the CMS 1522 reports prepared by the contractors. Consequently, STAR data are adjusted to reconcile to balances included on the CMS 1522 that is considered by CMS to be more reliable. For example, for four of ten sample items selected at one contractor, the STAR data did not agree to data in the providers' files.
- Although completed during October 2002, the formalized accounting policy and procedure manuals were not available during fiscal year 2002.
- The data match process is a process whereby CMS matches their data with data provided by the Social Security Administration and the Internal Revenue Service to identify potential accounts receivable transactions. For fiscal year 2002, CMS directed its contractors to reprioritize their activities toward debt collection rather than process MSP data match tapes. At September 30, 2001, accounts receivable related to data match was estimated at $110 million. It is reasonable to assume that additional receivables would have been generated and collected within FY 2002 from data match processes. While the impact is not material for financial statement purposes, the lack of data match activity initiated by CMS may adversely impact trust fund cash flows. The CMS has cited lack of resources as the basis for limiting the Medicare contractors' data match activities.

CMS Regional Office

Oversight duties for contractor processes and systems are shared by the central and regional offices, with the regional offices playing a critical oversight role in that they are the first point of contact for the contractors. Medicare regional offices are responsible for:

- Monitoring Medicare contractors to ensure that claims are processed in a timely manner.
- Ensuring benefit payments are made as specified by law.
- Assessing whether contractors have adequate controls in place to prepare financial reports and to determine that the reports are valid, accurate, and complete.
- Performing assessments to ensure corrective actions are taken to resolve prior findings.
- Monitoring contractors' compliance with systems security requirements through the performance of on-site reviews.
- Coordinating financial and system related engagements at Medicare contractors that include negotiating and assisting in providing responses to findings.
- Conducting Medicare Contractor Performance Evaluation (CPE) and quality reviews.
- Reviewing budget requests, and negotiating and recommending approval of Medicare contractor budgets with central office.
- Conducting financial and internal control reviews of Medicare contractor activities.
- Preparing financial reports and related analysis related to regional office activities.

During FY 2002, we visited two regional offices to assess the oversight function and found certain procedures not being adequately performed to ensure financial data provided by Medicare contractors is reliable, accurate, and complete. We noted the following:

- The CMS' national strategy called for national review teams to perform audit quality review program (AQRP) reviews of the audit activities at six of the 24 Part A contractors for a total of 35 providers compared to 25 reviews performed during FY 2001 and 125 reviews performed by outside contractors during FY 2000. The regional offices were not formally tasked with performing additional procedures to ensure appropriate coverage of the contractors.
- The CMS formed a workgroup to develop a national strategy for reviewing contractors' 1521 and 1522 reports in an attempt to address weaknesses identified during FY 2001. The workgroup developed a 1522 reconciliation protocol designed to ensure total funds expended reported on the 1522 are supported, complete, properly classified, and reconciled to supporting documentation. The CMS performed on-site reviews at six contractors utilizing the protocol. Oversight efforts beyond the performance of the on-site reviews were inconsistent among regional offices and the central office. While one regional office performed many of the steps outlined in the review protocol on a monthly basis, the second regional office performed no procedures at all to monitor its contractors' monthly submissions.
- Regional office priorities do not include periodic procedures to ensure the accuracy of reported accounts payable balances.
- The regional office is responsible for performing reviews of contactors' performance in various audit and reimbursements functions reported in the STAR. Although certain tests are being performed, the regional office is currently not testing the completeness of STAR data. Central office indicated that although CMS would like to review STAR data to a greater extent, limited resources are currently focused on areas of higher risk.

- Contractors are required to input eligible MSP debts into the debt collection system for external debt collection efforts by the Program Support Center. However, the regional office has not been reviewing the system to ensure the contractors are in compliance with CMS central office directives related to the process. Currently, the process is only reviewed through the national CPE review.
- The CMS has directed contractors to submit via the CR 1280 report its recommendations of MSP debts eligible for write-off to the regional office. Upon receipt, the regional office should review the recommendation and provide its approval/decline to the contractor and the central office within a certain period of time. During FY 2002, we noted that the regional office: (1) did not have adequate internal control to ensure timely receipt or adequate documentation to support the contractor's quarterly CR 1280 reports—eight of 60 were either not received or documentation could not be produced to support the submission from the contractors in a timely basis, (2) did not perform timely review and approval of the CR 1280—in one case noting a four month delay, and (3) had not consistently forwarded their response to the contractors' CR1280 report to central office. The regional offices indicated that in response to our review, they were currently developing enhanced processes to ensure the timely receipt and review of the CR 1280 reports and the timely forwarding of the regional offices' response to the contractor and central office.
- The regional office did not consistently obtain contractors' quarterly recommendations for classifying debts as currently not collectible. During our visits to two regional offices, we noted that eight of 60 reports had not been received from the contractors in a timely basis or that documentation could not be produced to support the timely submission. The regional offices have indicated that tracking sheets for these reports have been developed and will be used to track the timely submission of contractor quarterly reports and related documentation.

The GAO's *Standards for Internal Control in the Federal Government* indicates that internal control monitoring should assess the quality of performance over time and ensure that findings of audits and other reviews are promptly resolved. Without appropriate monitoring and oversight of contractor operations, deficiencies in internal control may allow material misstatements to occur without being identified in a timely manner.

Recommendation

We recommend that CMS continue to develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of Medicare activity. Specifically, we recommend CMS:

- Establish an integrated financial management system for use by Medicare contractors and CMS' central and regional offices to promote consistency and reliability in recording and reporting financial information, including accounts receivable and claim activity. Additionally, CMS should continue its efforts to promote uniformity of Medicare contractors' systems.

- Continue to refine its procedures to provide a mechanism for CMS central and regional offices to monitor contractors' activities and enforce compliance with CMS financial management procedures. This may include obtaining detailed subsidiary ledgers and related support from contractors for the CMS regional and central offices and reviewing subsidiary ledgers for reasonableness and reviewing reconciliations prepared by the contractors consistently on a periodic basis.
- Enhance the process of supervisory review at the central office, regional offices and contractor sites to identify errors in a more timely fashion. This should include enhancements to high-level exception driven analysis and the development of an archiving mechanism so that historical information is available for future trending; enhancing oversight procedures to monitor the implementation of control procedures to provide independent checks of validity, accuracy, and completeness of amounts reported to CMS. HIGLAS is expected to provide a foundation for improving oversight activities over financial activities.
- Although CMS has addressed these issues in its corrective action plans, CMS needs to continue to work to resolve system deficiencies that impair the contractors' ability to support and report accurate amounts in a timely fashion. The CAPs should be updated by the contractors in conjunction with the central and regional offices to ensure they identify specific requirements of claims processing systems to ensure they not only meet the reporting needs of the CMS central office, but also the contractor operating environments.
- We recognize that resource limitations may constrain CMS' ability to execute its mission. We suggest that management formally document the cost benefit conditions and prioritization process used to assess, for example, whether resources will be currently devoted to legislatively mandated MSP data match activities versus other mission responsibilities.

Medicare Electronic Data Processing (EDP) Controls (Repeat Condition)

Background and Scope of Review

The CMS relies on extensive, interchanged electronic data processing (EDP) operations at both its central office and Medicare contractor sites to administer the Medicare program and to process and account for Medicare expenditures. Adequate internal controls over these operations are essential to the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts.

The CMS central office systems are used to maintain administrative data, such as Medicare beneficiary enrollment, eligibility, and paid claims data, and process all payments for managed care. The Medicare contractors and data centers use several standard "shared" systems to process and pay fee-for-service claims. All of the shared systems are maintained by "system maintainers" and are interfaced with CMS' Common Working File (CWF) to obtain

authorization to pay claims and to coordinate Medicare Part A and Part B benefits. This network accounted for and processed more than $231 billion in Medicare expenditures during FY 2002.

Our review of EDP internal controls covered both general and application controls and did not include management or operational controls. General controls involve the entity-wide security program, access controls (physical and logical), application development and program change controls, segregation of duties, operating systems software, and service continuity. General controls impact the integrity of all applications operating within a single data processing facility and are critical to ensuring the reliability, confidentiality, and availability of Medicare data. Application controls include input, processing, and output controls related to specific CMS EDP applications.

We completed general control reviews at 12 Medicare EDP facilities that support the eight Medicare contractors sampled. Application controls were assessed for five shared Medicare systems at four separate contractors (the Fiscal Intermediary Standard System (FISS), the Arkansas Part A Standard System (APASS), the VIPS Medicare System (VMS), the Multi-Carrier System (MCS) and the CWF). We also assessed application development and program change controls at 11 Medicare EDP facilities and one system maintainer. We updated the status of findings reported upon in FY 2001 concerning general and application controls for seven contractors, three system maintainers, and the central office. Overall, we increased the number of general and application reviews and related control assessments performed as compared with FY 2001. Our reviews reflect the decentralized, yet interconnected and interdependent nature of Medicare operations that rely upon multiple EDP facilities to perform claims processing.

We reviewed the results of CMS-sponsored external vulnerability assessments performed during FY 2002 at three Medicare contractors. We updated the status of findings reported upon in FY 2001 as a result of CMS-sponsored assessments concerning vulnerabilities identified for three separate contractors and the central office. We also reviewed the results of CMS-sponsored SAS 70 independent service auditor reviews performed during FY 2002 for nine Medicare contractors whose operations were selected for the CFO audit claims sample. We noted that CMS continued their self-assessment process for Medicare contractor security and has enhanced their information on known system vulnerabilities. The results of these CMS-sponsored assessments continued to provide substantial and beneficial information about weaknesses that need to be addressed.

Overview of Results of FY 2002 EDP Review

In the course of the FY 2002 EDP review procedures, we continued to find numerous EDP general control weaknesses at the Medicare contractors, system maintainers, and the CMS central office. Though our review disclosed no exploitation of the identified vulnerabilities, such weaknesses could result in (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy data files, (3) improper Medicare payments, or (4) disruption of critical operations. Further, weaknesses in the contractors' entity-wide security structure do not ensure that EDP security controls are adequate

and operating effectively. Because certain financial reconciliation and report processes within CMS continue to evolve and require further improvement, the general and application controls related to access controls, systems software and application software development and change controls are critically important to CMS to ensure the integrity, confidentiality, and availability of sensitive Medicare data. No individual weakness was determined to be material, but in the aggregate, the matters noted below are a material weakness.

Medicare Contractors

Weaknesses were identified at the Medicare contractors in five primary types of controls, as follows:

- Entity-wide security programs
- Access controls (physical and logical)
- Systems software
- Application software development and change controls
- Service continuity

The CMS external business partner systems security initiative is believed to have the potential as a foundation program to address the vulnerabilities if adequately resourced and properly implemented and monitored. Expeditious efforts to build on that foundation are proceeding, but need to enhanced, as evidenced by the following summary of results from our reviews at the Medicare contractors:

Entity-wide security programs. These programs are intended to ensure that security threats are identified, risks are assessed, control objectives are appropriately designed and formulated, relevant control techniques are developed and implemented, and managerial oversight is consistently applied to ensure the overall effectiveness of security measures. Security programs typically include formal policies on how and which sensitive duties should be separated to avoid conflicts of interest. Similarly, policies on background checks during the hiring process are usually stipulated. Entity-wide security programs afford management the opportunity to provide appropriate direction and oversight of the design, development, and operation of critical systems controls. Inadequacies in these programs can result in inadequate access controls and software change controls affecting mission-critical, computer-based operations. Entity-wide security plan control weaknesses were identified at the FY 2002 review sites, and such weaknesses continue at certain sites reviewed in FY 2001. Certain contractors and the central office have not formalized all of their security plans and related programs that address federally mandated requirements. Funding provided to the contractors late in FY 2002 should facilitate the development of consistent security plans in FY 2003.

Access controls (physical and logical). Access controls ensure that critical systems assets are physically safeguarded and that logical access to sensitive computer programs and data is granted only when authorized and appropriate. Access controls over computer operating systems

and data communications software are also closely related. These controls help ensure that only authorized users and computer processes access sensitive data in an appropriate manner. Weaknesses in such controls can compromise the integrity of sensitive program data and increase the risk that such data may be inappropriately used and/or disclosed. Access control weaknesses continue to be identified and represent a significant risk to the Medicare program. Such weaknesses involved the configuration of access control software, policies and procedures for ongoing monitoring and review of suspected access violations, consistent security controls between mainframe and Internet-connected Medicare systems, and physical access to Medicare data centers. During penetration vulnerability testing at three Medicare contractors, weaknesses were identified that relate to dial-in access, user account and password management, Internet security, and systems software configuration. Funding was provided by CMS to the Medicare contractors late in FY 2002 to address gaps in access controls.

Systems software. Systems software is a set of computer programs designed to operate and control the processing activities for a variety of applications on computer hardware and related equipment. The systems software helps coordinate the input, processing, output, and data storage associated with all of the applications that are processed on a specific system. Some systems software is designed to change data and programs without leaving an audit trail. Overall, problems in managing routine changes to systems software to ensure an appropriate implementation and related configuration controls were identified. Specifically, we found that updates to systems software in non-mainframe environments that support Medicare claims processing were not applied timely. These non-mainframe environments also were found to have unnecessary system functions placed in operation, resulting in potentially unwarranted exposures subject to exploitation. Such problems could weaken critical controls over access to sensitive Medicare data files and operating system programs.

Application software development and change controls. The CMS has addressed the prior control weakness related to the Medicare fiscal intermediary data centers with access code to program source code for FISS through the implementation of improved monitoring controls and change management processes at the central office. However, additional weaknesses were identified at the Medicare data centers primarily related to the testing of new versions of the Medicare standard systems that are regularly provided as updates to the contractors. Such updates are implemented as a result of CMS' own Medicare program and operational planning activities and, additionally, changes mandated by legislation. We found that several contractors lacked formal change control processes and lacked sufficient documentation for changes made to systems. We also found that the Medicare data centers are generally unable to test all changes being implemented in the updated versions due to insufficient time between the release of the changed program codes to the data centers and the implementation dates. Without sufficient testing and adequate controls over changes made to the program codes as a result of either CMS program or legislative activities, there is insufficient assurance that all claims information is fully processed, which could result in inaccurate or improper Medicare payments.

Service continuity. Continuity plans provide a means for re-establishing both the automated and administrative processes related to the Medicare program in the event of a system failure. We found that several contractors did not have up-to-date, completed, and tested continuity plans to assure uninterrupted processing of Medicare data.

CMS Central Office

An update on the status of findings reported upon in FY 2001 at the CMS central office indicated that most important initiatives have been completed. Weaknesses continue to exist in the areas of entity-wide security plans, Medicare data file and physical data center access controls, and service continuity. Specifically, we found that not all central office system security plans have been completed, revised data access password standards have not been fully implemented for critical systems, and business continuity plans have not been completed for all critical Medicare systems.

Application Controls. Weaknesses were identified in the routine interchange of data between several critical applications and data sources, including Medicare beneficiary eligibility data received from outside agencies, the CWF, and several critical CMS central office data bases. We found that certain standard system edits could be bypassed but not detected timely and that updates to CWF databases using information from the central office may not be timely or complete. Because of the complexity of the interfaces and the current design of the Medicare applications driven by a claims processing environment with multiple dependencies, the reliability and integrity of critical Medicare information will continue to be impacted by such weaknesses.

Recommendation

The CMS continues to rely upon automated systems processed by the Medicare contractors for the consistent administration of virtually all aspects of the program. Detailed findings and recommendations for each full-scope review and follow-up review have been communicated to CMS management.

In FY 2002, CMS continued to make progress in identifying and addressing weaknesses in its automated processing systems. The CMS identified several additional weaknesses through the performance of vulnerability assessments, SAS 70 reviews, the compilation of Medicare contractor control self-assessments, OIG assessments and our procedures. These activities provide a base line for improvement. In discussing the results of these assessments with management, we understand that CMS will continue their assessment of the risks inherent in each vulnerability, assign priorities and seek additional resources as necessary to correct known deficiencies. We further understand that CMS is requiring all Medicare contractors to prepare system security plans in FY 2003. Unless these deficiencies are addressed, it is likely that symptoms of these weaknesses will continue to be identified.

The CMS management should, in conjunction with the central office and Medicare contractors and system maintainers that support the overall development, maintenance, and processing of the Medicare automated systems, continue to develop, implement, and monitor cost-effective controls to include:

- Consistent adherence to the OMB Circular A-130 guidelines for entity-wide security plans to ensure appropriate consideration is given to safeguarding Medicare data.
- Consistent and effective physical and logical access procedures, including administration and monitoring of access by Medicare contractor and central Office personnel in the course of their job responsibilities.
- Consistent and effective procedures over the implementation, maintenance, access, and documentation of operating systems software products used to process Medicare data. Appropriately controlled operating systems software products are fundamental to the integrity of the processing of Medicare data.
- Attention to appropriate segregation of duties to ensure accountability and responsibility for access to Medicare applications and data are appropriately assigned.
- Updated and appropriately documented service continuity procedures to recover Medicare processing in the event of a system outage.
- Adequate application controls are integrated into all Medicare systems to ensure that beneficiary and related financial databases are updated timely, accurately, and completely. Such controls should consider enhanced oversight by CMS to ensure consistency for all contractors.

STATUS OF PRIOR YEAR REPORTABLE CONDITIONS

The CMS demonstrated significant accomplishment by resolving its previously reported reportable condition related to Medicare Entitlement Due and Payable. Furthermore, CMS made significant progress by taking steps towards resolving the Medicaid Claims Estimated Improper Payments that is no longer classified as a reportable condition.

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In addition, we considered CMS' internal control over Required Supplementary Stewardship Information by obtaining an understanding of the agency's internal control, determined whether internal control had been placed in operation, assessed control risk, and performed tests of controls as required by OMB Bulletin No. 01-02 and not to provide assurance on internal control. Our procedures with respect to trust fund projections consisted of comparing amounts reflected in the Required Supplementary Stewardship Information to Trustee reports and spreadsheets prepared by the Office of the Actuary and did not include re-performance of actuarial computations or tests of underlying computations or related controls, if any. Accordingly, we do not provide an opinion on such controls.

In addition, with respect to internal control related to performance measures reported in the Management's Discussion and Analysis, we obtained an understanding of the design of internal control relating to the existence and completeness assertions and determined whether they have been placed in operation, as required by OMB Bulletin 01-02. Our procedures were not designed to provide assurance on internal control over reported performance measures, and, accordingly, we do not provide an opinion on such controls.

We noted other matters involving internal control over financial reporting, which we have reported to management in a separate letter dated December 10, 2002.

This report is intended solely for the information and use of the management of CMS and the Department of Health and Human Services, OMB, and Congress, and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

December 10, 2002

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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DEC 24 2002

Dear Sir:

This letter is in response to your audit report on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2002 financial statements. Your report identifies two material weaknesses: 1) Financial Systems, Analyses, and Oversight and 2) Medicare Electronic Data Processing (EDP) Controls. Each of these weaknesses is repeated from the FY 2001 audit of CMS' financial statements.

The CMS generally concurs with the findings and descriptions of weaknesses. As noted in your report, CMS has continued to make much improvement in the area of financial management during FY 2002. Specifically, we were successful in implementing many of the initiatives developed in the Chief Financial Officer (CFO) FY 2002 Comprehensive Plan for Financial Management that highlights CMS' key financial management activities and projects. These initiatives have greatly improved the consistency of financial reporting and Medicare contractor oversight. Additionally, we continue to stress to our Medicare contractors CMS' expectations and commitment to improving financial management and EDP controls.

We recognize that the financial weakness predominantly results from CMS' lack of an integrated general ledger accounting system that captures financial data at the Medicare contractor level. The Healthcare Integrated General Ledger Accounting System (HIGLAS) project, which is a commercial-off-the-shelf financial management system that will fully integrate CMS' accounting systems with those of our Medicare contractors, is underway. The HIGLAS project will strengthen CMS' financial management by standardizing the collection, recording, and reporting of Medicare financial information, as well as satisfy Agency accounting needs. The project includes pilots at two Medicare contractors before national implementation.

Although we are pleased with these results, we acknowledge the challenges we must address to remain committed to our goal of providing reliable financial information regarding the operation of CMS' programs. We will continue to track and report our progress on a regular basis.

I would also like to thank your office for their diligent work in completing the audit within the accelerated timeframes.

Sincerely,

Michelle Snyder

Michelle Snyder
Chief Financial Officer

Other Congressional Reports

FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT

The Federal Managers' Financial Integrity Act (FMFIA) requires executive agencies to report annually if: (1) they have reasonable assurance that their management controls protect their programs and resources from fraud, waste, and mismanagement, and if any material weaknesses exist in their controls, and (2) their financial management systems conform with Federal financial management systems requirements and Federal accounting standards.

The CMS assesses its management controls and financial management systems through: (1) management control reviews, (2) management self-certifications, (3) Office of Inspector General (OIG) audits, (4) the CFO financial audit, and (5) other review mechanisms, such as Statement on Auditing Standards (SAS 70) internal control reviews. As of September 30, 2002, the management controls and financial management systems of CMS provided reasonable assurance that the objectives of FMFIA were achieved. However, two material weaknesses (repeated from prior years) existed and a noncompliance was identified during the CFO financial audit.

Material Weakness 1: Financial Systems, Analyses, and Oversight

The Medicare contractors continue to make improvements in maintaining supporting records for Medicare activities and year-end balances. However, because the contractors lack a formal, integrated accounting system to accumulate and report financial information, they use ad hoc, labor-intensive reports, which increases the risk of material misstatement or omission. In addition, Medicare contractor controls over accounts receivable continue to need improvement.

At the CMS central office (CO), procedures were implemented that resulted in adjustments to accounts receivable balances reported by the contractors. However, these procedures did not ensure that accounts receivable activity included on the contractor financial reports was properly supported by detailed transactions. We did use formal procedures for financial reporting analysis.

We continue to provide instructions and guidance to the Medicare contractors and our CO and regional offices (ROs). We continue to contract with Independent Public Accountants (IPAs) to test financial management internal controls and to analyze accounts receivable at Medicare contractors. We created workgroups comprised of CO and RO consortia staff to serve as subject matter experts responsible for addressing four key areas: follow up on CAPs, reconciliations of funds expended to paid claims, trend analysis, and internal controls. As CMS progresses toward its long-term goal of developing an integrated general ledger system, we continue to provide training to the contractors to promote a uniform method of reporting and accounting for accounts receivable and related financial data.

Material Weakness 2: Medicare Electronic Data Processing (EDP) Controls

We rely on extensive EDP operations at CO and the Medicare contractors to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. In FY 2001, weaknesses at the Medicare contractors, as well as certain application control weaknesses at the contractors' shared systems, continued. Such weaknesses do not effectively prevent (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy files, (3) improper Medicare payments, or (4) disruption of critical operations. The OIG aggregated the findings at the Medicare contractors and CMS CO into one material weakness. No findings at a single location were considered material.

We continue to make progress toward resolving this issue by revising our information systems security requirements for Medicare contractors. The CMS Core Information Security Requirements adhere to guidelines in the Office of Management and Budget (OMB) Circular A-130 and implement effective control procedures. In FY 2002, we completed a prototype of a system security plan methodology for Medicare contractors and developed and implemented new background investigation procedures. We also developed policy and procedures for software quality assurance, as well as developed, tested, and implemented a systems software change audit review process.

Noncompliance

The CMS financial management systems—because they are not integrated—do not conform to government-wide requirements. We are following a comprehensive plan to bring our systems into compliance with the requirements. We have procured a systems

integrator to implement the Healthcare Integrated General Ledger Accounting System (HIGLAS). We have initiated implementation of an approved Joint Financial Management Improvement Program commercial off-the-shelf product at two Medicare contractor pilot sites.

MEDICARE'S VALIDATION PROGRAM FOR JCAHO ACCREDITED HOSPITALS

Introduction

Section 1865 of the Social Security Act (the Act) provides that hospitals accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) are deemed to meet the Medicare Conditions of Participation (CoPs). While JCAHO-accredited hospitals are not subject to routine Medicare surveys by the State Survey Agencies, subsection 1864(c) of the Act authorizes the Secretary to enter into an agreement with any such State Agency to survey JCAHO-accredited hospitals on a selective sample basis, or in response to allegations of significant deficiencies which, if substantiated, would adversely affect the health and safety of patients. The Act further requires, at section 1875, the Secretary to include an evaluation of the JCAHO accreditation process for hospitals in an annual report to Congress. This evaluation is referred to as the hospital validation program.

The purpose of the hospital validation program is to determine if the JCAHO accreditation process provides reasonable assurance that accredited hospitals are in compliance with the statutory requirements set forth at 1861(e) of the Act for participation in the Medicare program.

The JCAHO accreditation survey assesses a hospital's compliance with the JCAHO standards. Following the completion of an on-site survey, the JCAHO makes an accreditation decision. The accreditation decisions include: accreditation, accreditation with Type I recommendations, conditional accreditation, and no accreditation.[1] Accreditation means that the hospital meets all JCAHO standards and requirements. Accreditation with Type I recommendations means that the hospital is granted accreditation with the assurance that the identified recommendations for improvement are corrected. The JCAHO requires hospitals with Type I recommendations to submit a written progress report or undergo a follow-up survey. Conditional accreditation

[1] JCAHO accreditation decisions also include preliminary denial of accreditation and provisional accreditation. [The CMS does not recognize provisional accreditation for deeming.] The JCAHO considers all hospitals to be 'accredited' except those that are not accredited. The CMS currently accepts the JCAHO definition for deeming purposes.

results when a hospital is not in substantial compliance with JCAHO standards, but is believed to be capable of achieving acceptable standards compliance within a stipulated time period. Findings of correction, which serve as the basis for further consideration of awarding full accreditation, must be demonstrated through a short-term follow-up survey. Table 1 summarizes the JCAHO accreditation decisions for Medicare-approved hospitals receiving a triennial survey in calendar years 2000 and 2001.

TABLE 1
JCAHO Accreditation Decisions,
Medicare-Approved Hospitals Surveyed in 2000 and 2001

Accreditation Decisions	**No. Hospitals in 2000** *(Percent)*	**No. Hospitals in 2001** *(Percent)*
Accreditation	146 (9.5)	167 (10.8)
Accreditation with Type I Recommendations	1355 (87.8)	1349 (87.3)
Conditional Accreditation	41 (2.7)	28 (1.8)
Total Surveyed[2]	1543 (100)	1545 (100)

Changes in the Hospital Validation Program

Traditionally, the hospital validation program consisted of the Centers for Medicare & Medicaid Services (CMS) conducting a number of 'look behind' surveys at hospitals that recently had a JCAHO accreditation survey completed. Each year, CMS randomly selects approximately five percent of all JCAHO-accredited hospitals for validation surveys. The validation sample includes the following two categories:

1. Random sample (hospitals randomly selected to receive a Medicare survey within 60 days following the hospital's JCAHO survey).
2. Conditional sample (hospitals randomly selected that had a JCAHO accreditation decision of conditional).

In 1999 the HHS Office of Inspector General (OIG) issued a series of reports that prompted CMS to re-examine the hospital validation program and to determine what steps could be taken in order to improve JCAHO accountability for its performance

[2] Categories do not sum to total because table does not include all accreditation categories.

when accrediting hospitals. The CMS reviewed the weaknesses of the current hospital validation program and developed two new validation survey types—the Concurrent/Observational Survey and the Focused Survey. Both new survey types were piloted on a limited basis during FY 2001 in addition to the traditional validation surveys conducted.

The Concurrent/Observational Survey is an announced survey with a CMS Regional Office surveyor(s) observing the JCAHO triennial accreditation survey while the State survey agency concurrently conducts a full comparative survey. Regional Office observers record their observations of JCAHO standard implementation, survey process, and surveyor performance. The pilot Concurrent/Observational Survey was initiated in January 2001. The CMS and JCAHO worked in close collaboration to orchestrate and complete the five concurrent/observational surveys performed in FY 2001.

The Focused Survey is designed to determine a hospital's ability to maintain compliance with the Medicare CoPs between JCAHO accreditation surveys. The hospital is notified no more than 24 hours prior to the start of this survey. The Focused Survey is conducted between 60 days and 6 months following the hospital's JCAHO accreditation survey and examines specific standards of national or regional interest to CMS. The FY 2001 Focused Surveys were conducted to assess the hospitals' compliance with select Conditions of Participation. The CoPs selected, based on national interest, were: Patient Rights, Nursing Services, Pharmaceutical Services, and Quality Assurance as it pertains to pharmaceutical services and medication administration. A total of ten Focused Surveys were conducted during FY 2001.

The CMS has collected data on these new survey types that were introduced in FY 2001, and has included the results in the calculation of the disparity rate.

In the evaluation of the new survey types, feedback was solicited from the JCAHO, CMS Regional Offices, State survey agencies, and hospitals that were surveyed under the new methodology. Additionally, CMS has obtained the services of an independent contractor to evaluate the effectiveness of the revised hospital validation program and the outcomes of the survey pilots. That contractor is scheduled to complete its evaluation in the first portion of 2003, at which time CMS will determine what additional steps are necessary.

Validation Survey Findings

In FY 2001, 239 JCAHO-accredited hospitals were selected to receive a validation survey, with a total of 204 validation surveys performed by the State survey agencies. Table 2 presents the number of random validation surveys performed, along with the compliance determinations (i.e., if the results of a validation survey showed noncompliance with one or more CoPs, the hospital was 'out of compliance'). A hospital may have had deficiencies of a lesser severity (e.g., standard level) and still be considered in compliance. This table also included a comparison of the compliance pattern between validation surveys of accredited hospitals and routine surveys of nonaccredited hospitals.

TABLE 2
Compliance Determinations of Validation and Non-accredited Hospital Surveys, 2001

Survey Type	No. Hospitals Out of Compliance	No. Hospitals In Compliance	Total
Sample Validations	61	143	204
Routine Non-accredited	83	579	662

Table 3 presents compliance determinations for JCAHO-accredited hospitals by category of validation survey for FY 2001.

TABLE 3
Number of JCAHO-Accredited Hospitals Out of Compliance by Category for FY 2001

Survey Type	No. Hospitals Out of Compliance	No. Hospitals In Compliance	Total
Traditional Validation	52	137	189
Focused	4	6	10
Concurrent/ Observational	5	0	5

Deficiency data were analyzed for 22 Medicare hospital CoPs:

Federal, State, and Local Laws	Emergency Services	Anesthesia Services
Governing Body	Respiratory Care Services	Rehabilitation Services
Medical Staff	Nursing Services	Food & Dietary Services
Infection Control	Pharmaceutical Services	Outpatient Services
Quality Assurance	Laboratory Services	Medical Records Services
Discharge Planning	Surgical Services	Nuclear Medicine Services
Patients' Rights	Physical Environment	Radiologic Services
	Organ Procurement	

The three health and safety CoPs found out of compliance most frequently for the 204 validation surveys performed in FY 2001 are shown in table 4. The three CoPs found out of compliance most frequently for the 662 non-accredited hospitals surveyed in FY 2001 are shown for comparison.

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TABLE 4
Most Frequently Cited Conditions of Participation During Surveys, FY 2001

Accredited Hospitals	Frequency	Non-Accredited Hospitals	Frequency
1 Physical Environment *(includes Life Safety Code)*	40	Physical Environment	24
2 Infection Control	9	Infection Control	20
3 Nursing Services	8	Quality Assurance	17

Allegation Surveys

In addition to random validation surveys, CMS conducts substantial allegation (complaint) surveys on JCAHO-accredited hospitals. The CMS evaluates each complaint received on an accredited hospital. If CMS believes that the hospital would have a CoP out of compliance, we will then authorize the State Agency to conduct a substantial allegation survey.

In FY 2001, 2,482 allegation surveys of JCAHO-accredited hospitals were conducted with 101 found out of compliance with one or more CoPs. This means that 4 percent of the allegation surveys were substantiated by findings of non-compliance. Also, 350 allegation surveys of non-accredited hospitals were conducted with 36 found out of compliance with one or more CoPs. This means 10 percent of the allegation surveys in non-accredited hospitals were substantiated by findings of non-compliance at the CoP level. Table 5 summarizes the most frequently cited CoPs found during allegation surveys of accredited and non-accredited hospitals.

TABLE 5
Most Frequently Cited Conditions of Participation During Allegation Surveys, 2001

ACCREDITED HOSPITALS		NONACCREDITED HOSPITALS	
Condition Not Met	**Frequency**	**Condition Not Met**	**Frequency**
1 Nursing Services	43	Nursing Services	15
2 Governing Body	28	Quality Assurance	15
3 Patients' Rights	24	Infection Control	9

Rate of Disparity

The rate of disparity is the percentage of all sample validation surveys for which a State survey agency finds non-compliance with one or more Medicare conditions and no comparable condition level deficiency was cited by the accreditation organization. As set forth in regulation at 42 CFR 488.8(d), accreditation programs with a disparity rate of 20 percent or more are subject to a review to determine if that organization has adopted and maintains requirements that are comparable to CMS's. Of the 204 validation surveys performed in JCAHO-accredited hospitals in FY 2001, the State survey agencies found non-compliance with one or more conditions of participation in 61 hospitals. Comparing the validation survey reports of these hospitals with the JCAHO-accreditation survey reports, 12 of the 61 accreditation reports had findings comparable to those Condition-level deficiencies identified by the State Agency surveyors. This equals an overall disparity rate of 24 percent, a decrease from a disparity of 27 percent in FY 2000. As was the case in FY 2000, life safety code deficiencies account for more than 50 percent of the overall disparity rate.

In accordance with 42 CFR 488.8(d), CMS has initiated a review of the JCAHO requirements for life safety code (including standards, environment of care, and survey process) as they compare to CMS requirements. The CMS examined the methods used by the JCAHO to evaluate a hospital's compliance with the Life Safety Code through a facility self-assessment (Statement of Conditions or SOC) and the Plans for Improvement (PFI) documents. While CMS does not oppose the concept of the JCAHO's evaluation method for compliance with Life Safety Code (i.e., the SOC and the PFI), we have identified inconsistencies in its implementation that we believe contributes to the differences in the validation findings.

The CMS shared with the JCAHO a number of recommendations that we believe would improve the JCAHO evaluation of LSC compliance for hospitals. A brief description of the recommendations follows:

Completion of the Statement of Conditions by Qualified Personnel. The JCAHO should require that hospitals use certain types of personnel to complete the SOC. These requirements should specify both credentialing (e.g., architect, fire marshal, etc.) and specific knowledge, skills, and abilities.

Minimum Standards for the Content of the Statement of Conditions/Plan for Improvement. The JCAHO should set forth minimum standards for the SOC and PFI.

Submission of the SOC and PFI Documents to JCAHO Prior to Survey. The JCAHO should require that hospitals submit the SOC and PFI documents to JCAHO central office within a specified time frame prior to their accreditation renewal date (date certain). This would enable JCAHO central office personnel and surveyors to review the documents prior to beginning the survey. Currently, the surveyors do not receive the SOC and PFI documents until on-site at the hospital.

Increase Number of Life Safety Code Experts. The JCAHO should increase the capacity of Life Safety Code experts in their central office to review the SOCs and PFIs that are submitted by the hospitals prior to the survey. These individuals could evaluate whether or not these materials meet the standards set forth above, and identify areas of concern to determine the best course of action for the surveyors to take.

Develop Mechanisms for Facilities that Fail to Comply with the Time Frames for Correction. The JCAHO should develop mechanisms in the accreditation process for facilities that fail to follow their own time frames for completion of the tasks listed on their PFI.

The JCAHO has agreed to give serious consideration to the recommendations CMS set forth as they evaluate their own processes for assessing hospital compliance with the Life Safety Code. Additionally, CMS believes that the anticipated adoption of the 2000 edition by both CMS and JCAHO should help address some of the differences in validation findings. The CMS and JCAHO have both committed to working together to ensure that JCAHO's life safety code standards and survey requirements are at least as strong as Medicare's.

CLINICAL LABORATORY IMPROVEMENT VALIDATION PROGRAM

Introduction

This report on the Clinical Laboratory Improvement Validation Program covers the evaluations of FY 2001 performance by the six accreditation organizations approved under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The six organizations are as follows:

- American Association of Blood Banks (AABB)
- American Osteopathic Association (AOA)
- American Society of Histocompatibility and Immunogenetics (ASHI)
- COLA
- College of American Pathologists (the College)
- Joint Commission on Accreditation of Healthcare Organizations (Joint Commission)

We appreciate the cooperation of all of the organizations in providing their inspection schedules and results. While an annual performance evaluation of each approved accreditation organization is required by law, we see this as an opportunity

to present information about, and dialogue with, each organization in our mutual interest in improving the quality of testing performed by clinical laboratories across the nation.

Legislative Authority and Mandate

Section 353 of the Public Health Service Act, as amended by CLIA, requires any laboratory that performs testing on specimens derived from humans to meet the requirements established by the Department of Health and Human Services (HHS) and have in effect an applicable certificate. Section 353 further provides that a laboratory meeting the standards of an approved accreditation organization may obtain a CLIA Certificate of Accreditation. Under the CLIA Certificate of Accreditation, the laboratory is not routinely subject to direct federal oversight by CMS. Instead, the laboratory receives an inspection by the accreditation organization in the course of maintaining its accreditation, and by virtue of this accreditation, is "deemed" to meet the CLIA requirements. The CLIA requirements pertain to quality assurance and quality control programs, records, equipment, personnel, proficiency testing and others to assure accurate and reliable laboratory examinations and procedures.

In section 353(e)(2)(D), the Secretary is required to evaluate each approved accreditation organization by inspecting a sample of the laboratories they accredit and "such other means as the Secretary determines appropriate." In addition, section 353(e)(3) requires the Secretary to submit to Congress an annual report on the results of the evaluation. This report is submitted to satisfy that requirement.

Regulations implementing section 353 are contained in 42 CFR part 493 Laboratory Requirements. Subpart E of part 493 contains the requirements for validation inspections, which are conducted by CMS or its agent to ascertain whether the laboratory is in compliance with the applicable CLIA requirements. Validation inspections are conducted no more than 90 days after the accreditation organization's inspection, on a representative sample basis or in response to a complaint. The results of these validation inspections or "surveys" provide:

- on a laboratory-specific basis, insight into the effectiveness of the accreditation organization's standards and accreditation process; and
- in the aggregate, an indication of the organization's capability to assure laboratory performance equal to or more stringent than that required by CLIA.

The CLIA regulations, in section 493.575 of subpart E, provide that if the validation inspection results over a one-year period indicate a rate of disparity of 20 percent or more between the findings in the accreditation organization's results and the findings of the CLIA validation surveys, CMS can re-evaluate whether the accreditation organization continues to meet the criteria for an approved accreditation organization (also called "deeming authority"). Section 493.575 further provides that CMS has the discretion to conduct a review of an accreditation organization program if validation review findings, irrespective of

the rate of disparity, indicate such widespread or systematic problems in the organization's accreditation process that the requirements are no longer equivalent to CLIA requirements.

Validation Reviews

The validation review methodology focuses on the actual implementation of an organization's accreditation program described in its request for approval. The accreditation organization's standards, as a whole, were approved by CMS as being equivalent to, or more stringent than, the CLIA condition-level requirements*, as a whole. This equivalency is the basis for granting deeming authority.

In evaluating an organization's performance, it is important to examine whether the organization's inspection findings are similar to the CLIA validation survey findings. It is also important to examine whether the organization's inspection process sufficiently identifies, brings about correction, and monitors for sustained correction, laboratory practices and outcomes that do not meet their accreditation standards, so that equivalency of the accreditation program is maintained.

The organization's inspection findings are compared, case-by-case for each laboratory in the sample, to the CLIA validation survey findings at the condition level. If it is reasonable to conclude that one or more of those condition-level deficiencies was present in the laboratory's operations at the time of the organization's inspection, yet the inspection results did not note them, the case is a disparity. When all of the cases in each sample have been reviewed, the "rate of disparity" for each organization is calculated by dividing the number of disparate cases by the total number of validation surveys, in the manner prescribed by section 493.2 of the CLIA regulations.

Number of Validation Surveys Performed

As directed by the CLIA statute, the number of validation surveys should be sufficient to "allow a reasonable estimate of the performance" of each accreditation organization. A representative sample of the more than 14,000 accredited laboratories received a validation survey in 2001. Laboratories seek and relinquish accreditation on an ongoing basis, so the number of laboratories accredited by an organization during any given year fluctuates. Moreover, many laboratories are accredited by more than one organization. Each laboratory holding a Certificate of Accreditation, however, is subject to only one validation survey—for the organization it selected to maintain its CLIA certification, irrespective of the number of accreditations it attains.

Nationwide, fewer than 500 of the accredited laboratories used AABB, AOA, or ASHI accreditation for CLIA purposes. Given these proportions, very few validation surveys

* A condition-level requirement pertains to the significant, comprehensive requirements of CLIA, as opposed to a standard-level requirement, which is more detailed, more specific. A condition-level deficiency is an inadequacy in the laboratory's quality of services that adversely affects, or has the potential to adversely affect, the accuracy and reliability of patient test results.

were performed in laboratories accredited by those organizations. The overwhelming majority of accredited laboratories in the CLIA program used their accreditation by COLA, the College, or the Joint Commission, thus the sample sizes for these organizations were larger. The sample sizes are usually proportionate to each organization's representation in the universe of accredited laboratories, however true proportionality is not always possible due to the complexities of scheduling.

The number of validation surveys performed for each organization is specified below in the summary findings for the organization.

Results of the Validation Reviews of Each Accreditation Organization

American Association of Blood Banks

Rate of disparity: No disparity

Approximately 120 laboratories used their AABB accreditation for CLIA purposes. Seven validation surveys were conducted. No condition-level deficiencies were cited on any of the surveys, thus disparity was precluded.

American Osteopathic Association

Rate of disparity: No disparity

For CLIA purposes, approximately 50 laboratories used their AOA accreditation. Six validation surveys were conducted. This year, as in the previous years of CLIA validation review, disparity was precluded because no condition-level deficiencies were cited on any of the surveys.

American Society of Histocompatibility and Immunogenetics

Rate of disparity: No disparity

Approximately 130 laboratories used their ASHI accreditation for CLIA purposes. Six validation surveys were conducted. Condition-level compliance was found in all the validation surveys, thus disparity was precluded this year, as in the previous years of CLIA validation review.

COLA

Rate of disparity: 3 percent

Validation surveys were conducted at 95 COLA-accredited laboratories. Ten of the laboratories were cited with condition-level deficiencies. Comparable deficiencies were not noted by COLA in three of those laboratories.

Following is a listing of the laboratory identification number, location and condition-level deficiencies of the laboratories where COLA findings were disparate.

CLIA number	Location	CLIA Conditions
10D0692467	Florida	Quality Control—Bacteriology
26D0444419	Kansas	Laboratory Director
36D0339480	Ohio	Successful Participation—Proficiency Testing, Chemistry Proficiency Testing, and Hematology Proficiency Testing

College of American Pathologists

Rate of disparity: 2 percent

A total of 55 validation surveys were actually conducted at laboratories accredited by the College; however, 5 were removed from the pool because they were either not a survey of the entire facility or they were not conducted within the 90-day time frame. Among the remaining 50 laboratories, 2 were cited with condition-level deficiencies. Comparable deficiencies were noted by the College in only one of those cases.

Following is the CLIA identification number, location, and condition-level deficiency of the laboratory where the College's findings were disparate.

CLIA number	Location	CLIA Conditions
45D0670310	Texas	Laboratory Director

Joint Commission on Accreditation of Healthcare Organizations

Rate of disparity: 8 percent

During this validation period, a total of 53 validation surveys were conducted at laboratories accredited by the Joint Commission. Three surveys were removed from the pool because they were not performed within the 90-day time frame. Among the remaining 50 laboratories, 4 were cited with condition-level deficiencies. Comparable deficiencies were not noted by the Joint Commission in all four of those laboratories.

Following is a listing of the CLIA identification number, location and condition-level deficiencies of the laboratories where the Joint Commission's findings were disparate.

CLIA number	Location	CLIA Conditions
15D0362073	Indiana	Quality Assurance
17D0046777	Kansas	Laboratory Director
34D0240163	N. Carolina	Quality Assurance
45D0692852	Texas	Quality Assurance and Quality Control—Bacteriology

Conclusion

The CMS has performed this validation review in order to evaluate and report to Congress on the performance of the six laboratory accreditation organizations approved under CLIA. The findings of the validation review for FY 2001 indicate that all of the accreditation organizations performed at a level well below the 20 percent disparity threshold that would trigger a deeming authority review. Moreover, the validation review did not reveal widespread or systematic problems in accreditation processes that cause the equivalency of any organization's accreditation program to be questioned.

QUALITY IMPROVEMENT ORGANIZATIONS (QIOs)

Over the last several years, CMS has re-engineered the QIO program to better meet our strategic goal of improving the health status of Medicare beneficiaries. The QIOs still perform quality assurance activities in accordance with their original mandate. However, the principal focus of the QIO program has evolved from a mix of utilization review, diagnosis related group (DRG) validation and quality of care review to an expanded approach that features emphasis on quality improvement projects through the Health Care Quality Improvement Program (HCQIP). For the sixth round of QIO contracts, now in the final year of a 3-year cycle, a substantial level of effort is also being directed at Medicare program integrity via the Payment Error Prevention Program (PEPP) in compliance with the Balanced Budget Act.

The HCQIP relies on provider-based quality improvement, a data driven external monitoring system based on quality indicators, and sharing of comparative data and best practices with providers to stimulate improvement. The QIOs conduct a wide variety of improvement projects on important clinical and non-clinical topics that have the potential to improve care provided to many Medicare beneficiaries. Such projects vary in size depending on the study purpose and design. For example, there are national projects featuring six clinical topic areas (acute myocardial infarction, heart failure, diabetes, breast cancer, pneumonia, and stroke) that CMS has determined to have a high impact on Medicare beneficiaries; where the process measures are linked to outcomes; where room for improvement exists; and where QIOs have experience with the topic. Similarly, individual QIOs also design and structure local projects whereby they work collaboratively with specific providers and managed care plans in their areas, particularly with respect to disadvantaged and/or under-served beneficiary groups. The QIOs also conduct pilot projects in alternative provider settings.

Consistent with our strategic goal to promote the fiscal integrity of CMS programs, the PEPP activities are part of the Comprehensive Plan for Program Integrity to ensure Medicare hospital inpatient claims are billed and paid appropriately. Using CMS-

developed baseline data, each QIO is now required to identify the extent of payment errors occurring in its area; implement appropriate educational interventions aimed at changing provider behavior; and decrease the observed payment error rate. The overall target for the 3-year contract period is a 50 percent reduction nationally in payment errors for claims by acute care hospitals under Medicare's Prospective Payment System.

Under Federal budget rules, the QIO program is defined as mandatory rather than discretionary because QIO costs are financed directly from the Medicare trust funds and are not subject to the annual appropriations process. The QIO outlays in FY 2002 totaled $354.0 million, which compares with $329.2 million spent in FY 2001.

In FY 2002, CMS administered 53 QIO performance-based contracts, one per State, the District of Columbia, the Virgin Islands, and Puerto Rico. Program compliance is ensured via performance-based evaluation measures for both project results and program integrity efforts, as well as use of inter-rater reliability measures and International Organization for Standardization (ISO) 9000-type documentation of QIO processes.

2002 TOP CMS MANAGEMENT ISSUES LIST

The Reports Consolidation Act of 2000 requires an annual update of a list of the most serious management challenges, and management's progress in dealing with those challenges. Those challenges relating to CMS have been identified by the OIG and assessed here, along with a brief commentary from CMS management.

Management Issue #1: Payment for Prescription Drugs

Management Challenge

Because prescription drugs are such a significant part of 21st century medical care to help ensure proper treatment and maximum wellness, it is important that Medicare and Medicaid beneficiaries' access to pharmaceuticals is not hindered by overpricing. Overall, in calendar year 2001, Medicare Part B spent over $6.5 billion for prescription drugs. Similarly, in 2001, the federal share of dollars spent for Medicaid prescription drugs was nearly $14.3 billion.

The OIG has consistently found that Medicare pays too much for prescription drugs— more than most other payers. For example, Medicare payments for 24 leading drugs in 2000 were $887 million higher than actual wholesale prices available to physicians and suppliers and $1.9 billion higher than prices available through the Federal Supply Schedule. This has occurred because the reimbursement methodology is fundamentally flawed.

By law, Medicare's payment is equal to 95 percent of a drug's average wholesale price (AWP). However, the AWPs are not really wholesale prices; for the most part, they are reported by manufacturers to companies that publish drug pricing data. As OIG reports have indicated, the published AWPs that Medicare uses to establish drug prices bear little or no resemblance to actual wholesale prices available to physicians, suppliers, and large government purchasers. Further, because physicians and suppliers keep the difference between the actual price they pay for a drug and 95 percent of its AWP, they have a financial incentive to buy from a drug company with artificially inflated AWPs. Some may argue that the high drug payments are offset by insufficient Medicare payments to administer the drugs.

Several OIG reports indicate that Medicaid is also paying too much for prescription drugs because reimbursement methodologies are based on inflated AWPs. States should change their reimbursement methodologies to reflect the drug pricing categories, i.e., single-source innovator drugs, multiple-source innovator drugs not covered by the Federal Upper Limits, multiple-source noninnovator drugs not covered by the Federal Upper Limits, and drugs on the Federal Upper Limit schedules. Also, a connection is needed between how Medicaid pays for drugs and how rebates are calculated. Currently, any increases in pricing would not represent a corresponding increase in rebates; in fact, Medicaid could be paying more for drugs while getting less in rebates.

In recent large settlements, two pharmaceutical manufacturers allegedly set and reported some AWPs at levels far higher than the actual acquisition cost paid by the majority of their customers and caused those customers to receive excess Medicare and/or Medicaid reimbursement. To resolve their liability for this and other conduct, TAP Pharmaceuticals and the Bayer Corporation agreed to pay $875 million and $14 million, respectively, to federal health care programs.

Assessment of Progress in Addressing the Challenge

Despite attempts by CMS to work with the Congress to develop and implement more realistic Medicare and Medicaid reimbursement methods for prescription drugs, OIG reports continue to show that these flawed payment methodologies remain essentially unchanged. As of this writing, legislative progress is being made but a consensus bill has yet to be passed. However, BIPA gave the Secretary some authority to make administrative adjustments to the payment methodology in Medicare.

Management's Comments in Brief

The CMS continues to collect and analyze data on drug pricing and the costs of physicians administering drugs. For example, it is studying non-Medicare drug pricing of selected drugs covered under Part B to determine the feasibility of other approaches to more accurately determine AWP. In addition, the CMS has begun to utilize a single contractor to determine payment rates to eliminate the current variation in contractor prices.

Management Issue #2: Protection of Critical Systems and Infrastructure

Management Challenge

To accomplish its major missions of providing health care to the elderly, the disabled, and the poor; facilitating research; preventing and controlling disease; and serving families and children, CMS must rely on a distributed and open computing environment for information processing, knowledge sharing, and collaboration. Management, therefore, must establish security policies for information technology and monitor compliance; this process is essential for an effective IT security program.

Through Presidential Decision Directive 63 and the Government Information Security Reform Act (GISRA), the Federal Government has been mandated to assess the controls in place to protect assets critical to the nation's well-being and report on their vulnerability. The events of September 11, 2001 greatly heightened the awareness of the need to protect physical and cyber-based systems essential to the minimum operations of the economy and the government.

Assessment of Progress in Addressing the Challenge

CMS has made much progress in securing the most critical of essential assets. Core requirements for security controls were established and distributed, and systems architecture documents have been developed. However, recent OIG assessments (CFO and GISRA) found numerous information systems general control weaknesses in entity-wide security, access controls, service continuity, and segregation of duties. A collective assessment of deficiencies in Medicare systems resulted in the reporting of a material weakness in the FY 2001 CMS financial statement audit. While OIG has not found any evidence that these weaknesses have been exploited, they leave CMS vulnerable to: (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy data files, (3) improper payments, or (4) disruption of critical operations.

Management's Comments in Brief

The CMS is working with the Department of Health and Human Service's to comply with Presidential Decision Directive (PDD) 63. We are encouraged that the OIG has found no evidence that any security weaknesses have been exploited. In keeping with the requirements of the Government Information Security Reform Act of 2000, security remains a priority for CMS. To further strengthen our security posture, we have continued the emphasis placed on this functional area through implementation of a comprehensive systems security program that covers CMS internal operations as well as the operations of our Medicare fee-for-service contractors. To the extent of available resources, we have proceeded with security improvements and corrective actions. The program features initiatives in four fundamental areas: security policy, training and awareness, engineering, and oversight. A key feature of the program for the Medicare

contractors was the development and dissemination of codified core security requirements (CSRs).

During FY 2002, CMS received each Medicare contractor's second annual assessment of their compliance against the CSRs. Along with an independent contractor, CMS is completing its final evaluation of each Medicare contractor submission. The CMS requested, received, and distributed $9.7 million in additional FY 2002 funding for proposed safeguards and corrective actions. These safeguards and actions will be implemented throughout FY 2003. The CMS will continue to fund needed safeguards in future years, to the extent of available resources.

During FY 2002, CMS also developed and implemented a mandatory computer based training (CBT) security awareness course that all employees must complete by January 2003. The CMS began its own independent vulnerability assessment testing five years ago, and is aggressively cooperating with the OIG to improve the scope and coverage of such testing, especially for the Medicare contractor community. The level of awareness about the importance of security has been further enhanced since 9/11/01, and management of security issues is being appropriately addressed. The CMS endorses the importance of a healthy security program and hopes that this area will be a priority for resources in the future. An investment in security is essentially an investment in risk management. Such investment facilitates both remedial corrections and improved preventative measures across all of the Agency's activities.

The OIG has indicated that they intend to continue oversight of CMS's security program with additional reviews. The CMS will work with the OIG to ensure that these reviews are coordinated with similar OIG EDP reviews that are conducted under authority of the annual Chief Financial Officer's audit, GISRA, and PDD-63 to minimize the impact on ongoing operations.

Management Issue #3: Nursing Facilities

Management Challenge

Given the vulnerability of nursing home facility residents, it is imperative that appropriate and quality care be a top priority for all involved care providers. At the same time, payments need to be made accurately both to ensure financial stability for nursing homes and to protect the financial integrity of the Medicare program.

Financial controls and quality of care provided in nursing homes continue to be a focus of the OIG. In looking at nursing home resident assessments, OIG found differences between the minimum data set and the rest of the medical record, some of which may affect care planning. The OIG now has a number of additional studies underway. These include evaluations of the role of the nursing home medical director, quality assurance committees, nurse aid training, trends in survey and certification deficiencies, consistency and reliability of the certification process, identifying repeat

offenders in the certification process, social work services, and complaints to long-term-care ombudsmen. The results of these studies will be published over the coming year.

With respect to payments, OIG found that some services were paid for twice—once to the facility under the prospective payment system and again to the supplier. The OIG also examined the medical necessity of Part B therapy provided in nursing homes, both underutilization and overutilization, and found that 24 percent of the total allowed amount of this therapy in 1999 was paid in error. In addition, over one-third of Medicare Part B payments for psychiatric services in nursing homes were inappropriate.

Assessment of Progress in Addressing the Challenge

The CMS has made progress in Part A nursing home reforms, which are important to controlling fraud and abuse. The CMS issued a fraud alert addressing the prevalent types of errors found in OIG's initial review. Additionally, OIG recommended recovery of the improper payments and that CMS establish payment edits in its Common Working File and the Medicare contractors' claims processing systems to ensure that outside providers and suppliers comply with the consolidated billing provision.

The CMS agreed with the recommendations and indicated that meaningful progress had been made toward implementing edits to identify potentially inappropriate payments and recover overpayments. In addition, CMS issued a task order to one of its payment safeguard contractors to identify overpayments in three States. The OIG is continuing work in this area to determine if overpayments persist.

The CMS rolled out a nationwide nursing home quality initiative in November, which will make public facility-specific information regarding the quality of care in nursing homes to benefit those who are looking for a facility that can best provide needed care for a family member. This is an expansion of an earlier six-state pilot undertaken by CMS.

Management's Comments in Brief

The CMS concurs with OIG's assessment. The CMS has made significant gains in assuring that services being paid under the skilled nursing facility prospective payment system (SNF PPS) by fiscal intermediaries are not also billed to and paid by carriers. In April 2002, CMS implemented common working file (CWF) edits that will detect and deny cases in which carriers are being billed for services that the CWF shows to be in a Medicare covered Part A stay during the period in which the supplier billed the carrier for the service. In July 2002, CMS also implemented edits that will detect and mark payments that were made by carriers for persons in the course of a Medicare covered SNF stay where the SNF claim did not post to the CWF record before the carrier claim was paid, thus resulting in an incorrect payment. In January 2003, CMS plans to implement CWF edits that will detect similar incorrect cases in the fiscal intermediary claims processing system.

In addition, CMS has developed a website application that can be used by a physician, practitioner or supplier to determine if a service at the Common Procedure Coding System (HCPCS) level should be billed to the SNF (because it is bundled under SNF PPS) or to the carrier (because it is separately payable).

We believe that enforcement of longstanding policy through the CWF edits, combined with ongoing provider education efforts, will greatly reduce the problems created by failure of suppliers to seek payment from SNFs for services for which the SNF is being paid as part of SNF PPS.

Finally, CMS has made significant strides in its oversight of the SNF PPS through a program safeguard contract that examines the minimum data set 2.0 resident assessment data, including some on-sight reviews at nursing homes.

Management Issue #4: Medicaid Payment Systems

Management Challenge

Accuracy in the federal share of Medicaid costs is important to help ensure fairness across all state Medicaid programs as well as assure these federal health care dollars reach and achieve their maximum intended health care purposes. The OIG found that some states inappropriately inflated the federal share of Medicaid by billions of dollars by requiring public providers to return Medicaid payments to the state governments through intergovernmental transfers. Once the payments were returned, the states used the funds for other purposes, some of which were unrelated to Medicaid. Although this abusive practice could potentially occur with any type of Medicaid payment to public facilities, OIG identified this practice in two types of payments: (1) Medicaid enhanced payments available under upper payment limits (UPL) and (2) Medicaid disproportionate share hospital (DSH) payments.

Assessment of Progress in Addressing the Challenge

To curb abuses and ensure that state Medicaid payment systems promote economy and efficiency, CMS issued final rules, effective March 13, 2001 and May 14, 2002, which modified upper payment limit regulations in accordance with the Benefits Improvement and Protection Act of 2000. The regulatory action created three aggregate upper payment limits—one each for private, state, and non-state government-operated facilities. The new regulations will be gradually phased in and become fully effective on October 1, 2008. The CMS projected that these revisions would save $90 billion in federal Medicaid funds over the next 10 years.

The OIG commends CMS for changing the upper payment limit regulations. However, when fully implemented, these changes will only limit, not eliminate, the amount of state financial manipulation of the Medicaid program because the regulations do not require that the targeted facilities retain the enhanced funds to provide medical services to

Medicaid beneficiaries. The OIG also believes that the transition periods included in the regulations are longer than needed for states to adjust their financial operations.

The CMS intends to develop regulations that will outline accountability standards that states must address when making DSH expenditures. The OIG is continuing audit work on Medicaid DSH payments and will recommend program improvements once the work is completed.

Management's Comments in Brief

The CMS and the OIG have worked closely on analyzing the effects of the upper payment limit issue and regulations and plan to continue this effort. We also note that CMS has limited control over the length of the transition periods. The two and five-year transition periods were adopted pursuant to notice and comment rulemaking. The Benefits Improvement and Protection Act of 2000 further extended the transition periods by mandating the 8-year transition period.

Management Issue #5: Accuracy of Medicare Fee-for-Service Payments

Management Challenge

To help ensure the financial integrity of the Medicare program, continued access to Medicare benefits, as well as the long-term viability of the Medicare trust fund, it continues to be essential that documented and accurate bills are submitted for correct payment for properly rendered health care services. Based on a statistical sample, OIG estimated that improper Medicare benefit payments made during FY 2001 totaled $12.1 billion, or about 6.3 percent of the $191.8 billion in processed fee-for-service payments reported by CMS. These improper payments, as in past years, could range from reimbursement for services provided but inadequately documented to inadvertent mistakes to outright fraud and abuse. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. The overwhelming majority (97 percent) of the improper payments were detected though medical record reviews. While the OIG's 6-year analysis indicates continuing progress in reducing improper payments, unsupported and medically unnecessary services remain pervasive problems.

In addition to determining the overall Medicare error rate, we have conducted targeted audits and inspections to identify improper payments and problem areas in specific parts of the program. These reviews have included analyzing duplicate payments for the same service, payments made on behalf of deceased beneficiaries, and payments made for incarcerated beneficiaries. We have also determined payment error rates for specific supplies and services. For example, in a study of Medicare payments for orthotics, we found that 30 percent of orthotic claims in 1998 were inappropriately coded and therefore should not have been paid. We also found that in 1997, orders for 25 percent of sampled claims for blood glucose test strips failed to establish

beneficiaries' eligibility for the supplies. Additionally, in a review of 1998 home health services, we found an improper payment rate of 19 percent. Another review found that 24 percent of the total allowed amount of Part B therapy in 1999 was paid in error. Finally, we found that 27 percent of Part B mental health services provided in nursing homes in 1999 were unnecessary and lacked any psychiatric documentation. We will continue these targeted reviews to ensure that Medicare payments are made in accordance with program rules.

Assessment of Progress in Addressing the Challenge

The FY 2001 error rate is less than half of the 13.8 percent reported for FY 1996. We believe that since we developed the first error rate, CMS has demonstrated continued vigilance in monitoring the error rate and developing appropriate corrective action plans. In addition, due to CMS' work with the provider community to clarify reimbursement rules and to impress upon health care providers the importance of fully documented services, the overwhelming majority of health care providers follow Medicare reimbursement rules and bill correctly. In FY 2003, CMS will fully implement its Comprehensive Error Rate Testing (CERT) program to produce a Medicare fee-for-service error rate. CMS intends to run the CERT program in parallel with OIG's CFO audit for at least one year. After that time, OIG will continue to oversee this effort. The OIG will also continue targeted reviews of specific benefits where vulnerabilities have been identified to determine inappropriate payments in these areas.

Management's Comments in Brief

The CMS concurs with the OIG's assessment. In FY 1996, the OIG began estimating the national Medicare fee-for-service paid claims error rate. By FY 2000, the error rate was cut in half due in part to CMS's corrective actions which enhanced internal pre- and post-payment controls; targeted vulnerable program areas; and educated providers regarding documentation guidelines and common billing errors.

Since the OIG's error rate measure is valid only at the national level, CMS has been developing a new, more precise measure for use in the future. In May 2000, CMS awarded a Program Safeguard Contractor contract to implement the CERT program. The CERT program will produce national, contractor specific, and benefit category specific fee-for-service paid claims error rates. The CERT program began to be phased in starting in FY 2001. All contractors will be included in the CERT process by the end of FY 2002. The CMS is scheduled to replace the OIG fee-for-service error rate with CERT in FY 2003.

Management Issue #6: Medicare Contractors

Management Challenge

Because of the crucial role Medicare contractors play in helping facilitate efficient and effective health care delivery to 39.5 million Medicare beneficiaries, it is important that they be held accountable for their role in the health care financing and delivery system. For several years, OIG has been concerned about Medicare contractors' financial

management problems, such as accounts receivable documentation inadequacies and the lack of integrated dual-entry accounting systems; information systems control weaknesses; integrity issues; and weaknesses in the way they assign and maintain provider numbers so as to better safeguard the program and its funds. These failures could contribute to loss of program funds; improper payments; and manipulation, fraud, and abuse.

Contractor integrity continues to be an issue, and the potential for fraud exists. Since 1993, there have been 15 separate settlements or agreements (criminal and civil) involving Medicare contractors, resulting in over $400 million in HHS recoveries for alleged improper operations. In the last year alone, the OIG has identified contractor integrity problems which include a contractor who agreed to pay $76 million to settle allegations of misconduct while acting as a Medicare Part B carrier between 1966 and 1998. Among other things, the contractor had failed to process claims properly, then submitted false information to CMS regarding the accuracy and timeliness with which it handled those claims. In addition, a former Medicare fiscal intermediary agreed to pay $9.3 million to resolve its potential liability under the False Claims Act and Civil Monetary Penalties Law for allegedly falsifying data regarding its performance on Medicare cost reports.

Assessment of Progress in Addressing the Challenge

The OIG expressed an unqualified opinion on the CMS FY 1999 through 2001 financial statements largely because CMS continued to contract for validation and documentation of accounts receivable. However, once again OIG's FY 2001 financial statement audit disclosed that the lack of a fully integrated financial management system continued to impair the reporting of accurate financial information. To address these problems, CMS has initiated steps to implement the Healthcare Integrated General Ledger Accounting System (HIGLAS), expected to be fully operational at the end of FY 2007.

The FY 2001 reviews of information systems controls also disclosed numerous and continuing weaknesses at Medicare contractors, as well as application control weaknesses in contractors' shared systems. These vulnerabilities do not effectively prevent unauthorized access, malicious changes, improper Medicare payments, or critical operation disruptions. Corrective action is needed to address the fundamental causes of control weaknesses.

Management's Comments in Brief

The CMS concurs with the OIG's assessment and has been constantly striving to improve Medicare contractor financial management weaknesses. The CMS has made significant improvements in this area over the last few years as evident by the unqualified opinions on the CMS fiscal years 1999, 2000, 2001, and 2002 financial statements. The CMS long term solution for addressing many of these issues is the HIGLAS.

We have procured a systems integrator to implement HIGLAS and have initiated implementation of an approved Joint Financial Management Improvement Program commercial off-the-shelf product at two Medicare contractor pilot sites.

Other Congressional Reports

We also continue to validate the Medicare contractors' financial reporting by contracting with Certified Public Accounting (CPA) firms to conduct Statement of Auditing Standards (SAS) 70 internal control reviews and accounts receivable consulting reviews. The SAS 70 reviews concentrate on the functional areas of Electronic Data Processing (EDP) claims processing, financial management, and debt collection. The accounts receivable reviews ascertain the accuracy and completeness of the accounts receivable activity. Until HIGLAS is fully implemented, CMS will continue to rely on these on-going activities aimed at compensating for the lack of a modernized system. The CMS has also continued to revise and clarify financial reporting and debt collection policies and procedures based on various audit and review findings.

Our comprehensive systems security program includes the operations of our Medicare fee-for-service contractors. A key feature of the program for the Medicare contractors was the development and dissemination of codified core security requirements (CSRs). During FY 2002, CMS received each Medicare contractor's second annual assessment of their compliance against the CSRs. Along with an independent contractor, CMS is completing its final evaluation of each Medicare contractor submission. The CMS requested, received, and distributed $9.7 million in additional FY 2002 funding for proposed safeguards and corrective actions. These safeguards and actions will be implemented throughout FY 2003. The CMS will continue to fund needed safeguards in future years, to the extent of available resources.

Glossary

A

Accrual Accounting: A basis of accounting that recognizes costs when incurred and revenues when earned and includes the effect of accounts receivable and accounts payable when determining annual net income.

Actuarial Soundness: A measure of the adequacy of Hospital Insurance and Supplementary Medical Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.

Administrative Costs: General term that refers to Medicare and Medicaid administrative costs, as well as CMS administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-CMS administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. The CMS administrative costs are the costs of operating CMS (e.g., salaries and expenses, facilities, equipment, rent and utilities). These costs are accounted for in the Program Management account.

B

Balanced Budget Act of 1997 (BBA): Major provisions provided for the State Children's Health Insurance Program, Medicare +Choice, and expansion of preventive benefits.

Beneficiary: A person entitled under the law to receive Medicare or Medicaid benefits (also referred to as an enrollee).

GLOSSARY

Benefit Payments: Funds outlayed or expenses accrued for services delivered to beneficiaries.

C

Carrier: A private business, typically an insurance company, that contracts with CMS to receive, review, and pay physician and supplier claims.

Cash Basis Accounting: A basis of accounting that tracks outlays or expenditures during the current period regardless of the fiscal year the service was provided or the expenditure was incurred.

Clinical Laboratory Improvement Amendments of 1988 (CLIA): Requires any laboratory that performs testing on specimens derived from humans to meet the requirements established by the Department of Health and Human Services and have in effect an applicable certificate.

Cost-Based Health Maintenance Organization (HMO/Competitive Medical Plan, CMP): A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

D

Demonstrations: Projects and contracts that CMS has signed with various health care organizations. These contracts allow CMS to test various or specific attributes such as payment methodologies, preventive care, and social care, and to determine if such projects/pilots should be continued or expanded to meet the health care needs of the Nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.

Discretionary Spending: Outlays of funds subject to the Federal appropriations process.

Disproportionate Share Hospital (DSH): A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

GLOSSARY

Durable Medical Equipment (DME): Purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

Durable Medical Equipment Regional Carrier (DMERC): A company that contracts to process Medicare claims for purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

E

Expenditure: Expenditure refers to budgeted funds actually spent. When used in the discussion of the Medicaid program, expenditures refer to funds actually spent as reported by the States. This term is used interchangeably with Outlays.

Expense: An outlay or an accrued liability for services incurred in the current period.

F

Federal General Revenues: Federal tax revenues (principally individual and business income taxes) not identified for a particular use.

Federal Insurance Contribution Act (FICA) Payroll Tax: Medicare's share of FICA is used to fund the HI Trust Fund. Employers and employees each contribute 1.45 percent of taxable wages, with no compensation limits, to the HI trust fund.

Federal Medical Assistance Percentage (FMAP): The portion of the Medicaid program that is paid by the Federal government.

Federal Managers' Financial Integrity Act (FMFIA): A program that identifies management inefficiencies and areas vulnerable to fraud and abuse so that such weaknesses can be corrected with improved internal controls.

H

Health Care Prepayment Plan (HCPP): A type of managed care organization. In return for a monthly premium, plus any applicable deductible or co-payment, all or most of an individual's physician services will be provided by the HCPP. The HCPP will pay for all services it has arranged for (and any emergency services) whether provided by its own physicians or its contracted network of physicians. If a member enrolled in an HCPP chooses to receive services that have not been arranged for by the HCPP, he/she is

liable for any applicable Medicare deductible and/or coinsurance amounts, and any balance would be paid by the regional Medicare carrier.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Major provisions include portability provisions for group and individual health insurance, establishes the Medicare Integrity Program, and provides for standardization of health data and privacy of health records.

Hospital Insurance (HI): The part of Medicare that pays hospital and other institutional provider benefit claims, also referred to as Part A.

I

Information Technology (IT): The term commonly applied to maintenance of data through computer systems.

Intermediary: A private business, typically an insurance company, that contracts with CMS to process hospital and other institutional provider benefit claims.

Internal Controls: Management systems and policies for reasonably documenting, monitoring, and correcting operational processes to prevent and detect waste and to ensure proper payment. Also known as management controls.

M

Mandatory Spending: Outlays for entitlement programs (Medicare and Medicaid) that are not subject to the Federal appropriations process.

Material Weakness: A serious flaw in management or internal controls requiring high-priority corrective action.

Medicare Current Beneficiary Survey (MCBS): A comprehensive source of information on the health, health care, and socioeconomic and demographic characteristics of aged, disabled, and institutional Medicare beneficiaries.

Medicare Contractor: A collective term for the carriers and intermediaries who process Medicare claims.

Medicare+Choice: A provision in the BBA that restructures CMS authority to contract with a variety of managed care entities, including health maintenance organizations (HMO) and Competitive Medical Plans (CMP), both of which were previously allowed

to participate in Medicare, as well as preferred provider organizations (PPO) and preferred supplier organizations (PSO), religious fraternal benefit society plans, private fee-for-service-plans, and medical saving accounts (MSAs), for which the BBA authorizes a special demonstration for up to 390,000 beneficiaries.

Medicare Integrity Program (MIP): A provision in HIPAA that sets up a revolving fund to support the CMS program integrity program.

Medicare Trust Funds: Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.

Medical Review/Utilization Review (MR/UR): Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

Medicare Secondary Payer (MSP): A statutory requirement that private insurers who provide general health insurance coverage to Medicare beneficiaries must pay beneficiary claims as primary payers.

O

Obligation: Budgeted funds committed to be spent.

Outlay: Budgeted funds actually spent. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the States for Medicaid benefits.

P

Part A: The part of Medicare that pays hospital and other institutional provider benefit claims, also referred to as Medicare Hospital Insurance or "HI."

Part B: The part of Medicare that pays physician and supplier claims, also referred to as Medicare Supplementary Medical Insurance or "SMI."

Payment Safeguards: Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, MR/UR, provider audits, and fraud and abuse detection.

Program Management: The CMS operational account. Program Management supplies CMS with the resources to administer Medicare, the Federal portion of Medicaid, and other CMS responsibilities. The components of Program Management are: Medicare contractors, survey and certification, research, and administrative costs.

Provider: A health care professional or organization that provides medical services.

Q

Quality Improvement Organizations: Formerly known as Peer Review Organizations (PROs), QIOs monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and is of acceptable quality.

R

Recipient: An individual covered by the Medicaid program (also referred to as a beneficiary).

Risk-Based Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP): A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk HMO. Should the Medicare enrollee/member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

Revenue: The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

S

Self Employment Contribution Act (SECA) Payroll Tax: Medicare's share of SECA is used to fund the HI trust fund. Self-employed individuals contribute 2.9 percent of taxable annual net income, with no limitation.

State Certification: Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

State Children's Health Insurance Program (SCHIP) (also known as Title XXI): A provision of the BBA that provides federal funding through CMS to States so that they can expand child health assistance to uninsured, low-income children.

Supplementary Medical Insurance (SMI): The part of Medicare that pays physician and supplier claims, also referred to as Part B.

T

Ticket to Work and Work Incentives Improvement Act of 1999: This legislation amends the Social Security Act and increases beneficiary choice in obtaining rehabilitation and vocational services, removes barriers that require people with disabilities to choose between health care coverage and work, and assures that disabled Americans have the opportunity to participate in the workforce.

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The CMS welcomes comments and suggestions on both the content and presentation of this report. Please send them to Paul Konka by email or CMS, Mail Stop C3-13-08, 7500 Security Blvd., Baltimore, MD 21244-1850.

U.S. Department of Health and Human Services

Tommy G. Thompson, Secretary

Centers for Medicare & Medicaid Services

Thomas A. Scully, Administrator

The Chief Financial Officers (CFO) Act of 1990 (P.L. 101-576) marks a major effort to improve U.S. Government financial management and accountability. In pursuit of this goal, the Act instituted a new Federal financial management structure and process modeled on private sector practices. It also established in all major agencies the position of Chief Financial Officer with responsibilities including annual publication of financial statements and an accompanying report. The form and content of this ***Financial Report*** follows guidance provided by the Department of Health and Human Services, the Office of Management and Budget, and the General Accounting Office. It reflects the Centers for Medicare & Medicaid Services's support of the spirit and requirements of the CFO Act and our continuing commitment to improve agency financial reporting.

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